U.S. ARMY SERVICE FORCES.

RECONDITIONING CONFERENCE

SCHICK GENERAL HOSPITAL

CLINTON, IOWA

21-22 MARCH 1944

RECONDITIONING CONFERENCE

BRIGADIER GENERAL C. C. HILLMAN

Colonel Winn, members of the Conference and friends. Reconditioning is not a new idea. Over the years, physicians have realized that while their patients were recovering from illness or injury they might deteriorate physically and mentally so that when recovered from the primary cause of their admission to hospital, they still might be far from well. This has been amply demonstrated and doctors have attempted, possibly not to the optimum extent, to keep people occupied mentally and physically to the limits of their abilities in order to maintain functional activity of those parts of the body not otherwise restricted.

By appropriate effort to maintain the functioning of the parts of the body not incapacitated as the result of the primary illness or injury, the individual can be saved hospital days and can be returned to duty status in a functional capacity much higher than if attention were not paid to these things. In the present conflict when conservation of personnel is such a significant factor, the importance of reconditioning — in other words — the importance of maintaining the individual's mental and physical capacity at the highest point while he is confined has become of paramount importance, and, on this basis our Reconditioning Program is founded.

This Conference has been called with a view to coordinating our various plans for carrying out reconditioning in military hospitals, with a view to permitting us in the Surgeon General's Office to make contact with you gentlemen who are in charge of reconditioning in the various Service Commands, in order that we may learn what your problems are, and, in this way, be better enabled to carry out our functions in the Surgeon General's Office. Therefore, we have come here with a view to having a free discussion of our combined problems and enabling us to learn from you, as well as permitting us to pass on, in a small way, some of the thoughts we have about the Reconditioning Program.

I would like, before leaving the stand, to express the deep gratitude that the Surgeon General's Office feels and the personal gratitude of us who are intimately concerned in directing the Reconditioning Program, to the many individuals in the War Department, and in other agencies, for the interest and the help that has been given us. We are particularly indebted to the Assistant Chief of Staff, G-1, and Assistant Chief of Staff, G-3, of the War Department, to General Somervell himself, and to the Military Personnel Division, the Special Services, and the Morale Services of the Army Service Forces, and also to the American Red Cross for the assistance and cooperation which has been given in the closely related Arts and Crafts Program. We are deeply indebted to the Commanding General of the Seventh Service Command for the careful provisions which have been made for recording this meeting, and to the Commanding Officer of Schick General Hospital for the arrangements he has made for carrying out this meeting. We are indebted also to the press for coming here to take note of our proceedings, and to properly report them.

At this time it gives me special pleasure to introduce our host on this occasion, Colonel Dean F. Winn, Commanding Officer of Schick General Hospital.

COLONEL DEAN F. WINN

General Hillman and guests. We feel singularly complimented that Schick General Hospital has been selected for this Conference for the reconditioning of casualties in Army Hospitals, and that so many distinguished guests are here and have interested themselves in the program.

As long ago as last June, three months after this hospital received its first patients, and well in advance of the receipt of directives on the subject, we realized the need of segregating convalescent patients and the establishment of measures to fit them for duty. Accordingly, one barracks building was set aside for this purpose, and a convalescent detachment organized. Through our excellent public relations we were able to provide in the City of Clinton, facilities for swimming classes and for work-outs in a well-organized gymnasium under the direction of a trained physical director. Transportation was provided by the generous cooperation of the Red Cross Motor Corps. Since then our program has expanded, and you will hear more about this later from Major Johnson.

We are under no delusions as to the conduct of our Reconditioning Program. Circular 168 sets forth in a masterly manner the goal at which we are to aim. It is a relatively easy matter to prescribe a course to be set; it is a far different problem to put such a project into effect. The implementation of a training program for classes 3 and 4 is particularly nebulous. We have found it, at best, a trial and error proposition. This Conference will result, no doubt, in the solving of certain basic problems, and will assist installations in overcoming obstacles peculiar to the station concerned.

While you are here, every effort will be made to make you comfortable. If you need help, the Executive Officer or the Adjutant will know the answers. Administrative Offices will be open this evening until 2100 to afford information to those who may be interested in hospital administrative procedures.

There is one thing to which I would like to invite your attention before closing. This hospital is acutely food-waste conscious. You may be interested to know that in February our food-waste was only .079 lbs per man per day. This figure was attained in spite of the unpreventable waste incident to the feeding of sick patients. We have plenty of food and a menu second to none. Take all you want, and come back for "seconds", but -- eat all you take. We do not expect to have any edible food left on plates.

We bid you, for the Commanding General of the Seventh Service Command, and the Commanding Officer and Staff of this Hospital, welcome to Schick General Hospital.

BRIGADIER GENERAL C. C. HILLMAN: The Surgeon General's Office is particularly fortunate in having as its Director of the Reconditioning Division a Surgeon prominent in civilian life, who has been interested in this type of work for many years. In addition to his experience and interest as a civilian surgeon, he has been in the Medical Corps on active duty since the early days of the present struggle. He has had two years in one of the active theatres, and there he carried out his ideas in connection with reconditioning very effectively.

It gives me great pleasure to introduce to you Colonel Augustus Thorndike of the Surgeon General's Office.

COLONEL AUGUSTUS THORNDIKE

General Hillman, and guests. This conference has been assembled for the purpose of launching a reconditioning program designed to condition patients to such a state of health that when they return to a training or combat unit, they will resume their former assignment physically and mentally fit. Furthermore, it should be clearly understood there is an obligation to return those boys discharged by a certificate of disability, in the best state of physical and mental fitness that any individual handicapped may permit. The Surgeon General has announced on 10 December 1943, and thereby directed, that this program will proceed and "should be carried out in the case of all patients, regardless of whether or not it is anticipated they will become fit for return to duty."

Not only is it a Medical Department responsibility, it is the War Department responsibility. It has engaged the interest of the President, our Commander-in-Chief. It is very much tied in with the problem of "utilization of manpower." It is a significant honor to have Colonel Lynch attend this program today as the representative of the Assistant Chief of Staff G-1 -- Major General White. He has consented to inform us concerning matters pertaining to their interests in the salvage and training of Army personnel.

Because of difficulty in obtaining adequate personnel, results, to date, have not been produced to the extent desired. However, through the publication of Section II, Circular 73, the Commanding General, Army Service Forces, has now made provision for an organization with adequate personnel. As a result, there is a challenge to the reconditioning officers, to the hospital commanders, and to the Service Command Surgeons. My own experience as Commanding Officer of a general hospital overseas has proven to me that even with a lesser number of officers and qualified enlisted personnel, it was possible to return over 1,500 patients to full military duty in a period of five months, by means of a reconditioning section (an average of 300 per month). The value of any Reconditioning Program is judged only by its actual results. The Air Force knows its results. Let us know ours.

It behooves us to review our terminology. There has been too much confusion in the use of certain terms and classifications. It is most important that the word "rehabilitation" be dropped and the word "reconditioning" substituted and used in conjunction with all phases of this program except in the special case of the deaf and blind. There must be a common understanding that will not confuse "reconditioning" with the word "rehabilitation." The latter in military language suggests vocational training or a military detention camp. One will define the "Reconditioning Section" of a hospital as including all four classes of patients, classified according to Circular Letter 166, SGO. Classes 1 and 2 will be designated as the "Advanced Reconditioning Section." We must have a uniform terminology.

Excluding from this conference the special treatment which pertains to the blind and deaf and which is being carried out in especially equipped and staffed hospitals, the program is coordinated, so that Physical Reconditioning, Educational Reconditioning, Occupational Therapy and Recreational and Diversional Activities are all integrated into a composite schedule. It is of greatest importance that this coordination exist in all hospitals. You will hear from subsequent speakers today and tomorrow how this is accomplished.

In concluding these opening remarks, it is my privilege, as Director of The Reconditioning Division in The Surgeon General's Office to point out that this conference marks a milestone in Patient Reconditioning in the United States Army.

Remember that every commander in the field, from squad leader to the highest headquarters, is interested in the success of the Medical Department's return to full military duty of patients physically and mentally fit. Remember, that every mother, every sister, every father and every brother is interested in the physical and mental welfare of his or her nearest of kin. This program is designed to produce results in all Service Commands. The responsibility is ours. We cannot fail! General Porter, General Hillman and Colonel Lynch, I assure you, we will not fail.

BRIGADIER GENERAL HILLMAN: Though we must keep in mind that patients in the Reconditioning Program are still patients, and that first of all it is our obligation to give consideration to the ailment or injury that has necessitated the individual's hospitalization; we must not forget that, while the individual is undergoing reconditioning, there is afforded a magnificient opportunity to instruct that patient -- train him -- and further prepare him for the military task that lies ahead. We must keep in mind that training should be directed along military lines as far as possible, and the ultimate goal should be to prepare the individual, either for a better effort in the military forces, or to enable him to better take his place in civil life, and thereby contribute to the military effort.

In working up our program, we have been especially fortunate in having the cooperation, encouragement, and help of Assistant Chief of Staff G-3, Major General Ray E. Porter. It is my pleasure at this time to introduce General Porter.

MAJOR GENERAL RAY E. PORTER

Gentlemen: These are busy days for me, as they are, in fact, for all of us; however, I feel entirely justified in devoting the time to the subject of Reconditioning which was required for my attendance at your conference here.

I came here with two purposes in mind. My first purpose is to evaluate for myself, and to be able to report to the Chief of Staff, the adequacy of the plans which have been announced for our Reconditioning Program, and to judge the probable capabilities of the officers who have been charged with the execution of those plans.

The second purpose of my visit is to impress on you, by my presence here, the importance that the Chief of Staff and entire War Department ascribe to the Reconditioning Program.

The importance of the Reconditioning Program is indeed one of the first magnitude. The young man who has sacrificed any part of his mental or physical strength in the defense of his country is entitled to every opportunity to recover his impaired opportunities to the fullest possible extent. His loved ones who gave him to their country are entitled, if humanly possible, to receive him back capable of contributing to their support and happiness rather than having him return as a burden, and as a cloud to overshadow their future joys.

These men who go forth and sacrifice for their country are the men with souls and characters to make America worth the price in blood and tears that is being paid in her defense. Their loss, or their impaired usefulness, will be an irreparable loss to our country.

We owe a debt to our sick and wounded soldiers, to their families, and to future America which must be met if we are not, justly, to sacrifice all confidence in our leadership.

In another phase the Reconditioning Program is of tremendous importance.

The magnitude of the present World conflict has impressed all of us, as we had not realized before, how definitely limited the manpower resources of the United States really are. We are prone to deal in superlative adjectives, to think we have the greatest, largest, and mostest of everything and I am sure most of us are already realizing we haven't the mostest men, to the extent we once thought we had. I am convinced that, by employing our numbers fully, economically and wisely, our strength is equal to the demands of victory. I am just as thoroughly convinced that even relatively minor wastages in our manpower will seriously jeopardize our chances of complete victory.

It is important that all of you should leave here knowing that we have in our Army today only 7,700,000 men and women. We can't expect to ever get many more. To maintain the industrial demands made on our country, we cannot withdraw from industry a much larger force and hope to continue to support our armed forces. It is important for you to know before you leave, if you don't already know it, that every man and woman of that 7,700,000 is definitely assigned to some place. There is no reserve. If it becomes necessary to provide a company of a new type, we must find a unit of equal strength, and inactivate that unit to provide personnel for the new unit. Every man who has left his duty has left behind a vacant place for which there is no man to fill. These are alarming facts to me, and they certainly tend to emphasize the importance of the work you are doing.

Those young men who will come to you for reconditioning were the cream of the crop. They will be the men who have already learned how to win. Every one of them you lose for the Army, every day that one of them remains away from duty longer than is absolutely necessary to his full recovery, is a damning charge against all of us and an irreparable loss of our cause.

I am deeply interested in every service we are able to render to our sick and wounded soldiers; however, it is the training of the convalescent soldier who can be saved for the Army that is the official responsibility of my Division of the War Department General Staff.

Training for men who are to return to duty must include:

Mental reconditioning
Physical reconditioning
Retraining for new military duties, or refresher training for the military duties formerly performed by the soldier.

I do not hesitate to say that mental reconditioning is the most important of the three activities you must undertake. In many cases, it will be the most difficult.

Success will only be achieved through personalized effort. Those conducting this training must have their hearts and souls in their work. They must deal with each trainee as an individual. They must understand each individual; they must gain the confidence and respect of each individual; and they must administer to the peculiar needs of each individual. I am sure problems of mental reconditioning cannot be accomplished through any mass methods.

It is in the field of mental reconditioning that our Orientation Program and our Orientation Officers should make a noble and effective contribution. If we could send each reconditioned soldier back to the Army with an unfaltering faith in the righteousness of our cause and an unbending determination to win, they would constitute the mightiest single force for victory available to us.

And I ask you why can't we do just that? If Germany, with her propaganda of lies, has fired her youth with enthusiasm for their cause that burns in the heart of every German soldier with whom I have talked during this war, why should we, with the glorious truth to sell, fail to inspire every single young American. We have failed to achieve full success in that field but I don't believe we can justify our failures.

With reference to the orientation work, you will probably be told by General Osborne's representative here about the General's intense interest in this program, and I can assure you that he is prepared to go all out in helping you making your work a success. In the fields of physical reconditioning and military training, you will require both instructors and equipment. The War Department is prepared to help you to the limit of its resources in obtaining both. I have already promised things which I have not the slightest idea on earth how I am going to get. I have even committed some of my associate general staff divisions to do things that I haven't had the heart to tell them about. However, we will give you, I assure you, everything available to us to help you make this program a success.

In the matter of instructors, I think it is important that you use convalescent officers and soldiers to the maximum extent of their ability as instructors. This will have two great advantages. Their records will give them a prestige among their comrades that will make their instruction far more effective than it would normally be, and I think that it will be of the greatest service to the instructors, themselves, in aiding their own recovery. They again will have something useful to do, and they again, will be assuming responsibilities, and I am sure those two facts will do more to speed them along toward more rapid recovery than any single thing we could possibly do for them.

You are entitled to receive every possible assistance from local commanders in the matter of instructors and training aids. However, many of you will be located in places where there are no field units or where there are only a few. You must solve your problems of military training and physical conditioning by working out a worthwhile program and asking for, and continuing to ask for, until you receive it, adequate assistance in the way of instructors, together with the necessary military equipment and training aids.

I shall not attempt to enumerate the subjects which should be included in your training programs. My present thought is that training programs should not be rigidly standardized throughout the Army. You should be guided by the individual needs of your trainees, and you should take the fullest advantage of local facilities. You must not, under any circumstances, overlook the worthwhile military training or retraining of these convalescent soldiers. Probably the greatest importance that that training will have is that it again gets the man to thinking along military lines. It will also serve a very useful purpose in preparing the man to do his job better when he goes back to duty, so please do not let the military training aspects of your program be weak or something that you just put in to fill in the morning. You don't kid the soldier. He doesn't mind doing something worthwhile, but he is terribly bored doing something put in the program just to fill the morning. We have seen a lot of that done. Please don't do that. Get someone who is capable of managing it for you, and get the personnel and equipment you need to make it a worthwhile program.

There is one point on which I am probably not qualified to speak as an expert, but on which I have very definite ideas.

It is this: During his reconditioning training, the soldier should be removed as far as possible from the hospital atmosphere. If possible, I think we should cease to refer to him as a patient and find a place for him to sleep, eat and work as far removed from the other patients as possible. From my observations in life, without any scientific background for my conclusions, I have decided that for each and every one of us there is a time beyond which we cannot continue to be a patient and be anything else. It may be six weeks for one man and two months for another, but if we remain patients long enough, we will eventually cease to be anything else.

Gentlemen, as I said in the beginning of my remarks, one of my purposes in coming here was to judge for myself the capabilities of the men to whom this work is being entrusted. I don't hesitate to say, as I look out over your group this morning, that I am quite happy to see the type of officer who has been brought into this work. It shows the importance those responsible have placed on this program. I think the plans which have been prepared by Colonel Thorndike, approved by the Surgeon General, and approved and published by the Commanding General of the Army Service Forces, are certainly a long step forward toward an effective reconditioning program. However, you must recognize that the most complete, most detailed and the soundest plans are of no importance whatsoever if they are implemented by incapable men--by men who are not putting their best efforts into that implementation. You certainly have an inspiring task ahead of you. One of the regrets I have as I near the end of my life, is that I have devoted my life so wholly to the study of destructive measures, that it has seemed to me more and more in late years that it would be such a satisfaction to think I was contributing something constructive to life. With that thought so constantly in my mind, it is not surprising that I really envy you this great opportunity to do one of the most constructive pieces of work which can be assigned to any group of officers. Thank you very much.

GENERAL HILLMAN: Thank you, General. In carrying out the reconditioning program, a great many problems arise which have to do with the administration of personnel. In handling our personnel problems we are very fortunate in having the entire support of the Assistant Chief of Staff, G-1, who works in full accord and cooperation with us, and we profit much by the advice and assistance given. We have with us this morning, as representative of the Assistant Chief of Staff, G-1, Colonel E. C. Lynch. It is a pleasure to introduce Colonel Lynch.

COLONEL E. C. LYNCH: General Hillman, members of the conference and guests. I know that General White regrets very much not being able to be present with you this morning and at the subsequent meetings of this conference. Unfortunately he was unable to attend. I say he would regret being absent because he has an intense personal interest in the reconditioning program and the expected effects which will result therefrom.

General Porter has ably covered the War Department General Staff aspects of the reconditioning program. There is little that I can add to his remarks, except as repitition. From a personal point of view, there are two essential features in the reconditioning program which cannot be stressed too much. The first point is to preserve the quality of our soldiers. After we have spent months training a soldier, it is important that we keep his mental condition in a proper state so he will not deteriorate mentally while undergoing medical treatment. In that respect you have a most important part of the reconditioning of the man.

The second point is that our experience thus far indicates that a well run reconditioning program will result in speeding up the convalescent period for the average patient. Getting the man back into the flow sooner represents a considerable gain in manpower. As General Porter pointed out, we are now limited to a ceiling of 7.7 million for the Army. In order to get the full effectiveness from that 7.7 million, it is necessary that the maximum number be on the job. If the reconditioning program reduces the number of days a man requires in convalescence before he goes back on the job, we have made an equivalent saving in manpower.

GEN. HILLMAN: In the station hospitals of the Army Air Forces, a wonderful opportunity has been presented to do constructive work in reconditioning. The Commanding General of the Army Service Forces, the Air Surgeon and his staff have taken full advantage of this opportunity and have developed, within the Army Air Forces and the station hospitals thereof, a very fine reconditioning activity. In personal charge and directly responsible for this success is Lieutenant Colonel Howard A. Rusk, Medical Corps, Army Air Forces. I am pleased to introduce Colonel Rusk.

LT. COL. HOWARD A. RUSK

General Porter and gentlemen: I appreciate very much, sir, the privilege of coming to this conference and discussing with you and learning from you new ideas about the overall reconditioning program. I should like to tell you about the first survey made when this program was started in the Army Air Forces at one of our station hospitals. We sent enlisted men through the wards inquiring of the patients as to their reaction to this program. The first group said, "This is some Army where a man has to work in a hospital. I understand that there is something going on where you have to go to classes and take exercise and see training films, even when a patient." The other group said, "It looks like they are going to do something for us and get us out of the hospital." In the entire hospital there wasn't a single man who didn't say he wouldn't welcome the ideas of the reconditioning program which is now in effect in the Army Air Forces station hospitals.

Our fifteen months experience has given us a number of interesting observations. The most interesting series has been our patients with virus pneumonia. In the survey of 1,850 patients, 600 were segregated and put into a special group. They were sent to alternate convalescent wards. In Ward 1, they did nothing but the old regime; they sat around the ward; went to the PX; walked to mess; and when they felt able, were sent back to duty. In Ward 2, they were kept in bed 8 days longer than in the other ward. They were put in the twelve day reconditioning program which started with one-half hour the first day and ended on the twelfth day with a ten-mile hike with a full pack. Group 1 averaged 45 days with a 30 % recurrence rate and Group 2 averaged 31 days with 3% recurrence rate.

We recently have run a test on fifty patients and believe we know one reason why these boys get out sooner. We have found that if we start convalescent virus pneumonia patients positive with x-rays or hyperventilation; give it every hour throughout the day and follow with 24-hour x-rays, 90% of this group of fifty cleared up in 72 hours. It looks as though the reconditioning program with the exercises and natural hyperventilation was accomplishing the same thing. We are not absolutely certain, but it seems to clear up the atelectasis which is believe responsible for the delay in convalescence.

In contagious diseases we have been able to drop the average of a week from their hospital time. In our orthopedics, where we have made a number of different physical checks and have checked time time on patients in casts that have been kept in top physical condition, we found that when the cast is cut they can be back to duty in half the length of time.

Keeping the muscles of the rest of the body active improves the rate and volume of blood supply to the fixed muscles and although not definitely proven, this probably prevents the atrophy of blood capillaries which otherwise occurs in atrophied nuscles. For this reason the reconditioning of the fixed nuscles takes a much shorter time. Our readmissions have been cut as much as 25%. We have a series now of four months of observation of every patient discharged from the hospital and we find their physical fitness is 5% better than the average of the camp. We feel hopeful from that figure.

The teaching, in this program, as General Porter has pointed out, must meet the need of the installation and that has been a problem in our Service because we vary in meeting basic needs. However, if you take advantage of the post or station facilities where you are and utilize the material at hand and key your program to that need, the interest maintenance will be at the top level. We have now been giving credit for hospital training in our Cadet Centers and Basic Training Centers so that the man can parallel the course he is pursuing in the hospital and when given an examination on discharge, if he passes, is given full credit for the time he spent in the hospital and will be losing no training time.

All this goes back to the point of how to sell this program to the patient and I think it can be sold in one way - that is - "What does it do for me, Private John Doakes?" It does three things for him. First, it gets him out of the hospital sooner. In the second place, he has less chance of coming back because reinfections are less likely to occur and third, if he carrys on his work in the hospital, that he did in camp, he will be up with his outfit. He will get out sooner - he, probably won't come back - and he will keep up with his outfit and that is all a soldier needs. You will get wholehearted participation from this approach.

As you know, we have set up eight convalescent centers in the Air Forces to receive patients from general hospitals for specialized convalescent training. It was done because the Air Forces had a special problem. We are dealing primarily with highly trained, technically skilled, individuals and young air crews. Our object is to attempt to get the men back to their original assignment with the same MOS number, or, even if they have to have a new MOS number to put them where they will be of most value to the Air Forces. This is our objective, so when we receive a man from a general hospital, he is put in a general overall program which includes retraining with a vocational trend.

The opportunities section is a section for vocational guidance of casualties and is manned by men who have had special experience with Air Force personnel needs and needs of the aircraft industry. The vocational counselors follow the Doctor and have been a tremendous morale factor. They have four pieces of a puzzle to put together with these individuals. The first is, what does the individual want to do? Second, what can he do with his disability; third, where can we place him in the Air Forces, and fourth; if he has to be discharged, how can we help him to be placed in a self-supporting, self-respecting civilian job. Up to the present we have gone only this far.

The Air Service Command employs some 400,000 civilians in its depots and runs 30 schools and teachs 700 specific jobs. Trained men may be placed here with a Civil Service rating and a priority of discharge. We have a backlog of jobs in the aircraft industry we are trying to fill with the men who have been discharged. In addition to these, we go through the usual agencies. These men start in a broad vocational training, whether it be radio, metal work or engine overhaul. If they are to be discharged so, we will have already started them in their vocational training for the work they will follow in military or civilian life.

I think, Gentlemen, that the success of failure of this program, both for us and for you, depends upon the heart that we have in it. No man, in my opinion, regardless of his training, will be of any help to you in this program unless he feels it first in his heart. If he has such a feeling and such a desire to serve, and if he has a little bit of imagination and an average amount of energy, he will set up a program that nothing can stop. This program of reconditioning, of salvaging and of convalescent training, is not a program for the Air Forces, Service Forces or Ground Forces, it is a program for all of us together to get to the soldier and, by working together, and by an exchange of ideas and by cooperation, we can go so much farther and so much faster. I feel that with such cooperation we can do what General Porter has suggested. It is the goal in this whole program, and is, "The debt of disability which shall be paid in the currency of opportunity."

GENERAL HILMAN: Thank you, Colonel Rusk. Before introducing the last speaker, I would like to remind you that we have a very busy schedule and it will be necessary to step lively to get from one part of the program to another in order to carry out the full program of the conference. In selecting a place for this conference, two things were in mind. Primarily, we wanted to have this program at a hospital where reconditioning was being carried on in an exemplary fashion. Secondly, it was desired to find a place in the center of the United States which was convenient. Colonel Winn, as an officer of long service in the Army, and keenly conscious of the professional side of medicine, is admirably fitted to set up such a program and, at this hospital - The Schick General Hospital - has established a fine program of reconditioning. Under General Winn, acting in direct charge of the program, as his Reconditioning Officer, is Major E. G. Johnson. I think that after seeing the demonstrations you will soon have an opportunity to see, you will agree that Major Johnson has done a very excellent job at Schick General Hospital.

MAJOR E. G. JOHNSON

Colonel Winn has already given you a brief statement of the history of the reconditioning program. We started to work with Class I and II in June of last year and started work with Class III and IV in the early part of November.

In order to present the demonstrations, in the order shown in the Agenda, there has been some shifting of our normal scheduled activities. You will notice certain activities which are ordinarily held outdoors will be held indoors, partially due to the climate and partially due to the fact that the actual location at which they are held is immaterial. First, I would like to tell you about the staff who is helping us with this program.

I am Chief of the section receiving considerable advice and help from all of the sections of the hospital - Surgical, Medical, NP, Red Cross, a very cooperative Chaplain's office and many others.

Captain Rosenfield, who has been working with us part time, represents our morale services. Special Services brings in civilian speakers from local communities for the patients or those on tour.

Lieutenant Gagnon, convalescent detachment -- that will be the first program you will see this morning -- is in charge of Class I and II patients in the gymnasium.

Lieutenant Zimmerman is running the athletic part of the program, taking care of considerable part of our educational activities in connection with United States armed forces, university extension courses, occasional speaking courses, typewriting and what not.

In addition to this permanent staff we have received considerable help from the Classification Officer, the Chief of Physio-Therapy and Occupational Therapy Sections of the hospital and an officer whom we call a professional liaison officer who comes in and helps in the classification of our patients.

I would like, for a moment, to explain more fully that the classification officer is very important. He is a member of the Adjutant General's Department. We obtained him as an aid to this program. He classifies the patients according to our needs. The ward officer may find out that a patient has been misassigned or has been incapacitated partially for further duty. There may be a question as to whether a man is worth anything from the standpoint of a military job. He is sent to the Classification Officer accompanied by his prescription -- negative facts are given -- the man cannot do this, that or the other thing. He is then interviewed. Form 20 is examined and a positive recommendation is made. This is forwarded to his next station. It has proven a very valuable morale builder -- both in the cases of battle casualties as well as those post casualties who may consider himself misassigned. We can talk to him and straighten things out.

We are very acutely aware of the morale problem of patients, assigned from overseas as well as those local stations and realize that the factor of individual personality enters very strongly. We must deal them as individuals. We have a questionnaire which has on it a number of questions which bring out the man's personal interest. He can indicate what he would like to do and what he has done and what his education was before he came in the Army. The ward leader fills the questionnaire out with him and through the questionnaire they get to know each other. In this way the ward leader knows the man's problems, and knows what he wants to do for continuing work. The ward leader also acts as a platoon leader for a group of ward sections and knows each man in it; is trained to give general calisthemics; sees that Class III patients are sent down to the gymnasium and if he stays in the ward, gives them general calisthenic work and handles activities associationed with ASF aids. He fills out questionnaires and helps them carry on with their studies. Any problems which may arise may be taken by this ward leader to the proper officer on our staff.

The NP patients -- the difficult problem -- do not fit into a program of this nature; they are handled under the supervision of their own ward officers. They participate in certain activities provided for all, but if, for example, a battle film might interfere with their returning to a permanent foundation and it is to be shown and discussed, that period will be filled in with a gymnasium exercise period. We have obtained special films for the NP patients of a vocational guidance nature. A great many of these men do not return to duty, and these films in their way, help in readjustment. Gymnasium work has proved satisfactory as a group activity. The Red Cross has been very helpful with the NP cases.

The afternoon lecture series is a lecture series by civic leaders in the community, a judge, perhaps a superintendent of the Dupont industry or something of general interest. Our morning lecture period is on orientation and military training. With a large group of patients from all branches, it is rather impossible, except in small groups, to coordinate a balanced system of military training for Class III patients. So the lecture is used by our officer patients who preview the films and discuss the branch of service to which the picture pertains, from the standpoint of orientation and military service and as to what sort of work they do. Then the film will be discussed afterward if it is appropriate.

Group discussions are held in the afternoon with the patients participating in panel discussions. Three or four patients will work up a very pertinent problem of the day or some problem in which they all have shown interest. Class III patients -- the advanced reconditioning section -- is handled in a detachment barracks because we are unable to provide facilities from the post. They are handled as a service detachment from a military standpoint. If they go on sick call or complain of a headache or a belly ache, they are classified and examined by the chief of the section or by the liaison officer.

The training program for Classes I and II is considerably easier than for Classes III and IV; however, you have the problem in a general hospital of a mixed group. This has been handled by using the review training series of lectures and demonstrations covering the basic subjects common to all branches. For example, an air corps patient -- an air corps officer or cadet -- will work up a little series on some subject in which he is particularly interested and carry it on for the patients. Code classes are utilized, typewriting classes, hikes. This is the usual program here for all Classes I and II. In addition we have had a few patients who fall in between Classes II and III. They may have to stay in a reconditioning section a little bit longer -- that is in the advanced section a little longer for healing purposes.

Officer patients are participating in the program but not as much as they will in the future. With our experience so far, I think we will have very little trouble with them. In the reconditioning section we have from three to eight officers who very ably assisted the training program. We had a little trouble at first but it was soon ironed out regarding the question of staying close to the enlisted men. They were not in squad rooms; they had rooms to themselves. We are going to start a program in the officers ward, but you won't see that today. They will run into orientation and be spread in small groups through the hospital. Orientation classes are held in large groups in this auditorium here. I will be at one of the round tables tomorrow and will be glad to take up any unanswered problems at this program. I think you all have the agenda of the day's activities. We have just about time enough to get down to the gymnasium to see the first part of the program. This morning the groups are all together. This afternoon the groups will be divided into one and twos.

COLONEL THORNDYKE: We will now conclude this morning's session and follow Major Johnson to the gymnasium.

END OF MORNING SESSION

COL. THORNDIKE: The meeting will please come to order. For the next half hour or so, we have planned a question and answer period. We have been taken through a very interesting tour of the hospital and seen the program as it can be put on. I am sure there are questions concerning which that have come to many of us that we would like to perhaps obtain some special information. Colonel Winn has agreed to answer the questions -- well, I think he has. However, he has one of his patients here whom I think you would all like to hear from as to how successful the patient feels the program is.

COL. WINN: Sgt. Dorio, will you come forward. We're going to insert an unplanned item on this program. I thought you might be interested in hearing from a patient -- what the patients think of the program. We thought this up on the way up to the auditorium -- this idea of having a patient tell you of what the patients think of this program. Sgt. Dorio was on his way to mess and is mad, so anything he will say will be impromptu and not influenced by anything the staff has told him to say.

SGT. CARL DORIO, 17th Bomb Wing: Thank you, Sir. Officers of the Army, distinguished guests, ladies and gentlemen. I consider, indeed, it a great pleasure to stand before you and tell you in my own words my personal reaction to the reconditioning program here at Schick General Hospital. I have been separated from my organization, from my buddies, from my flying outfit in the Air Corps, since August, 1943, because of the accident I happened to be in just before we were ready to take off on a mission against the enemy and help bring victory to our country and our people. I came to this hospital on October 6, last year. At that time there wasn't any recondition program. Of course, I am not just a youngster about 18 or 19, I'm a little older than some of the soldiers. I have social work background and I can, more or less, navigate by myself. In other words, I can read and do a lot of things which take up time, but even so, I felt the need of something else -- something organized, something more constructive -- than anything I could make by my individual effort. I was looking for something but there wasn't anything here. Towards the latter part of October, as I remember it, or along about in November, we began hearing of a reconditioning program. At first, the men in the wards poked fun at the idea. They were wondering what some of the officers were up to. Between stories, the officers told us about a reconditioning program, about what some of us are fighting for and all that sort of thing, and in a little while some of the men, while still skeptical, were no longer cynical about the program. Captain Rosenfield started various activities and we cracked all kinds of jokes about him. Since then, however, most of us have learned to respect Captain Rosenfield because the men -- all of them to my mind -- feel that he and Major Johnson, of whom we don't see so much, have been doing a splendid job.

The Reconditioning Program, both physically and mentally, offers us a means to keep fit and to keep our morale high while patiently waiting for that day when we rejoin our outfits and go over and do the job which has to be done.

Now, what are some of the things this program has done? Well, for myself, I had a fracture of the right leg and a fracture of the right arm, so as far as my right side was concerned, it was practically useless. I was in bed for many months -- I couldn't write a letter. I wanted to write letters and I had to do something about writing. I am also interested in writing fictional short stories and I didn't want to lose what skill I had, and so, with the help and encouragement of the officers, I learned to write left-handed and now I am ambidextrous. Of course, before this, no one could read my right hand writing and now they can't read my left-hand writing. I feel a little like an octopus -- is it this or is it that? Anyway, it served me very well during that period. My cast just came off about two or three weeks ago.

During that period, instead of just staying in bed, I was able to learn to write, and now I can write practically as well left handed as right-handed. I think that was quite an achievement, not only for me personally but also for the program.

Some of us yearned for some mental exercise. Some of us couldn't march around -- I still can't -- but we wanted something of an intellectual nature, so they started this panel discussion. They said that we could discuss problems that might be of interest to us. We were given a lot of leeway and we appreciated it. We rotated chairmanships, and we rotated the members of the speaking team. We have discussed all kinds of problems. For example, we discussed the Baruch Report last week, which was very interesting to us men. We discussed the problems of war and the Teheran and Moscow Conferences. We have discussed the soldier voting bill -- we have discussed rehabilitation, reconditioning after the war, and all the problems we are facing now and will have to face later.

Some of us wanted to keep up with current events. We felt that while we were training and carrying on our activity in active service, we had sort of lost track of things and so it was made possible for us to have a forum every Wednesday night in the Red Cross Auditorium. We have had maps supplied us and all kinds of materials to carry out these discussions. We have two-hour sessions during which we review the war news of the week, highlights of national affairs in Washington, and questions of international importance which may have been propounded during that week. Now to some, who may have other activities, that may not sound like very much, but it was a great thing to us, who have not been out for so many months, to be able to exercise our mental functions in that way. It was a great achievement. It afforded us great pleasure.

Then something else -- some of us, when we became ambulatory, wanted to do a little something extra and some of us who had radio experience wanted to know if we couldn't speak on the radio and tell the good people of Iowa how we reacted to a number of things they were doing for us. We wanted to tell them what we were thinking about, what we wanted to do when we got out, and it was made possible for us to have a radio program where we tell the people of the surrounding country what the service man here at Schick Hospital is thinking about. We called the radio program "Personalities in the News at Schick Hospital". For instance, tomorrow evening, we are going to talk about the hospital organization here which has done so much for us. This is one form of activity for us. It affords us great pleasure and takes up our time. These are just some of the things.

Other boys are learning to make various things in the wards -- boys who can't get around -- such as rugs or belts or many other things which are part of the occupational therapy part of the program. Then, of course, when we are able to graduate to what is known as "C" or convalescent ward, we begin to take light exercises. I was sent over there Friday, and I am beginning to take some light exercises physically which is toning me up very nicely, and I think it is going to stimulate the growth of bone in my fracture. My hand is getting stronger and I am feeling good. The only thing I feel bad about is that I can't go out where the fighting is going on. I would say that in my own humble judgment this program has tremendous possibilities.

I understand that another angle to this is the development of the library facilities here. A number of the boys like to read and review books and then get up before an audience and discuss them. I understand that they are going to have the opportunity to do this before other patients. It takes up time, but more than that, it develops intellectual powers.

Some of the boys have to learn new skills. Some of us, unfortunately, will have to return to civilian life, and will have to be prepared to meet the problems of civilian life. As a result of our study, I think we will be able to make that readjustment more readily because of this program. In other words, those of us who leave here to return to either our fighting outfits or to civilian life will be better soldiers, better fighting men, or better civilians because of it. I want to go back to my outfit. My morale has never been any higher than it is right at this moment. If we go back to civilian life, we can go into a defense industry. We can help production so that we will have victory as quickly as possible. That is my judgment of a reconditioning program. It is doing a great deal to help us recover much faster physically and mentally. It is keeping us in trim physically and keeps us mentally on our toes. When we leave here, we will be better soldiers and better Americans to help free this country in the quickest possible time. When it is all over we are going to be better citizens to help make a greater American democracy which will have liberty and prosperity for everybody and lasting peace for the whole world. Thank you very much.

COL WINN: Because we are a little behind on our program, I am going to have to forego the pleasure of hearing from another patient--Sgt. Storey--our non-commissioned officer who leads the panel discussions. He has expressed his desire to tell us his story about what he thinks, but I don't believe we have time. We certainly appreciate his willingness to do so.

This meeting is open for discussion. I am inclined to think the eloquent story just given you has answered some of your questions already.

COL THORNDIKE: Are there any questions from the floor?

COL MOORE: Please discuss the merits and disadvantages, if any, of having reconditioning carried on through the appropriate sections of the hospital rather than centralized in one area where it will be all under close control of the operation heads of each section.

COL THORNDIKE: Colonel Moore, I want to explain that reconditioning involves all four classes and if you remove it to another area you will still have to have Class III and IV patients in the hospital. You meant, I imagine, the merits or disadvantages of having Class I and II patients separated from the rest. It is preferable to separate these two classes from the hospital atmosphere and move them out to a camp or barracks away from the patients. Such a camp has been established about fifteen miles from Walter Reed in an old CCC camp, and it seems to be working very ideally. There is a separate mess and separate administration for the reconditioning. The medical officer comes over and holds sick call for the patients. That is the ideal, I believe, but remember, they are still patients in the hospital and carried as patients. Does that answer your question?

COL WINN: I would like to explain the operation of the system at this hospital. A survey was made of the community surrounding the hospital, and there were no available places we considered suitable for this activity. We did have barracks space. We feel that having these patients close to us makes the program a little bit better integrated. I don't believe the fact that the barracks are near the hospital is detrimental. I believe it would be preferable to have these convalescent patients subsisted in a mess with duty personnel. In this hospital, that is precluded by higher authority which insists that we conduct two separate kinds of messes: the field ration for duty personnel and garrison ration for patients.

So far as we know, no economy is effected by this method. On the contrary, it is against work simplification. However, we have not been able to influence anybody in changing the method of messing.

COL THORNDIKE: Any other questions? The chair hearing no further questions, the meeting is adjourned. We will assemble at 1300 for the showing of a motion picture reel sent over from England by Colonel Dively, showing the reconditioning program in operation in the European theatre.

END OF AFTERNOON SESSION

COL. AUGUSTUS THORNDIKE: Will the meeting please come to order. We have prepared, and on the desk you will find a graphic organizational chart of reconditioning and how it pertains to the various headquarters. You will note the dotted line is the staff line and the solid line is the line of command. We have just obtained approval of these charts before I came out, so they are authorized officially and are the organizational charts of reconditioning. I have three slides which I will show and then I will call on the next speaker.

(SLIDES SHOWN)

Are there any questions on these slides? If not, I shall call on Colonel Winn to give us a talk on the subject of utilization of personnel. Colonel Winn.

COL. DEAN F. WINN: General Hillman, Colonel Throndike, guests: I assume that the Program Committee intended this talk to be based on how the personnel which has been set up in ASF Circular 73 may be utilized rather than how this hospital is utilizing personnel now assigned to the reconditioning program. When I wrote this talk I had never seen these charts we have just looked at so my remarks may be a little bit off in some places.

The increase of current personnel ceilings to provide for reconditioning programs and the provision for keeping this personnel stabilized will be a tremendous help in the conduct of reconditioning activities.

Circular Letter No. 168, SGO, sets forth in a clear and stimulating fashion the purpose of the program and character of work to be performed. No program of reconditioning will be successful unless it receives the earnest, enthusiastic support of the entire hospital personnel.

Commanding Officers. The Commanding Officer must take an active interest and must exert himself to sell the idea to his staff.

Chief of Section. The Chief of the Reconditioning Section must have abounding enthusiasm, great insight, and organizing and planning capacity. A background in training troops would prove useful. He should give his full time to the project. He, also, has a responsibility in selling reconditioning not only to his assigned assistants, but to the hospital staff, new patient increments, and to all the auxiliary services whose help he will need.

The utilization of a Medical Corps officer to at least initiate the program and get it going is desirable chiefly because of his familiarity with hospital operation and his vision and insight regarding the many medical problems affecting the various types of patients to be serviced.

In our organization chart the reconditioning section has been rated at the same level as the several professional services. Experience may prove that an especially well-qualified officer of the Medical Administrative Corps could conduct a well-running section; or perhaps any properly qualified Branch Immaterial officer could be used. Such a non-professional officer should be qualified by training in educational and physical conditioning. He should have some formal or practical background in psychology.

The Chief of the Section should be utilized to plan and organize the program and supervise its functioning in order to assure the full utilization of his assistants and of ancillary services. He should not be tied down by any routine duties foreign to his job or even incident to his job.

He should hold frequent conferences with his assistants and act as a consultant to them and to individual patients whose problems are particularly difficult. He should keep the hospital Commander advised as to the conduct of the program and as to the results being obtained.

Educational Officer. (2 enlisted or civilian assistants) This officer will be responsible for the carrying out of academic educational training, "quickie" language courses, illiteracy classes, typing classes, military training classes, and the like.

Academic Education. He should interest himself in seeing that selected patients take advantage of the educational facilities afforded by U. S. Army Forces Institute Courses. He should devise means for getting information to patients of the existence of these courses. He should arrange for interested patients to contact him directly or through his enlisted or civilian assistants. From a guidance standpoint he should determine the advisability of a patient beginning the follow-up course desired or a modification of the patient's choice, in some instances contacting by mail the high school or college at which the patient formerly was enrolled. (Some high schools credit a man with one point for each promotion in grade). He should assist patients in preparing and dispatching their applications for these courses. He should make known to patients the availability of appropriate text books in the hospital library. He should organize special classes for groups, perhaps obtaining the assistance of the services donated by professors or school teachers in nearby institutions. He should catalog patient instructors who are uncovered by his assistants or by others who have been requested to be on the lookout for such individuals.

"Quickie" Language Courses. He should stimulate interest in "quickie" language courses. While these courses have proven their usefulness for individuals who undertake them seriously and with a sustained interest, one may expect sharp rises and declines in the utilization of this activity. In the conduct of this project he should encourage the use of other patients as instructors who know the language, and should not overlook the feasibility of utilizing gray ladies, civilian language teachers, and so forth.

Illiteracy Classes. It is probable that the Red Cross staff will be the most fruitful source of aid in conducting these classes.

Typing Classes. He should be prepared to maintain typing classes since this is an activity for which there will nearly always be candidates. It not only has practical training application but may well tie in as a form of occupational therapy.

Military Training Classes. Classes in camouflaging, identification of aircraft, radio code, hygiene and sanitation, and the like, must be a part of the continuing program. Hospital staff personnel and patient officers and enlisted men of appropriate branches fit well into this type of instruction.

Orientation. He should maintain close liaison with the Post Morale Services and Special Services Divisions in order to be certain to obtain and be able to disseminate the latest orientation materials to the patients through any available medium, such as movies, orientation talks, discussion groups, posters, bulletin boards, and patient publications. In this activity overseas officers and enlisted patients may be used with great advantage to the instructors as well as to groups. The educational officer may be able to arrange, if he maintains close liason with the Public Relations Officer, tours by groups of patients to industrial plants and points of historical interest. It has been observed that this activity has a fine public relations effect. An attempt should be made to include in these groups patients who are prospective cases for separation from the service by C.D.D.

He should assist the Public Relations Officer in selecting battle casualties for attendance at public functions, such as bond rallies, patriotic gatherings, war plant "E" awards, and so forth.

Physical Education - Class 3 and 4. (1 NCO per 500 normal beds) The assignment of 1 NCO per 500 normal beds is probably predicated upon the idea that all Class 3 and 4 physical educational activities are to be carried out in the wards or in areas adjacent thereto. With such a conception this personnel should be used to train ward masters to supervise calisthenics for bed patients and ambulatory patient exercises and games and to supervise the execution of this program. The utilization of ward masters for this purpose has been reported to have been successful in some installations. It has been used in this hospital in only a limited degree because it has been felt that in active wards it might interfere with the normal duties of ward attendants in the care of the sick and thereby preclude their unfailing execution of this duty; because of the frequent shifting of ward attendants; and chiefly, because it has been our plan to carry on Class 3 physical education in the gymnasium rather than in the ward. If it is planned to give physical exercises to Class 3 patients in the ward, it is not clear how the most efficient use could be made of the gymnasium which is provided for this purpose. Would it not be preferable not to specialize these instructors but to utilize them, together with the two enlisted men allotted to the educational officer, in the coordination and supervision of the participation of patients in all activities?

We have designated enlisted men assigned to the reconditioning program as ward leaders to distinguish them from the ward masters. The term appeals to us and I am inclined it should be adopted. The giving of rank to these men is going to be a big help. As you noticed this afternoon some of these men who are leading these classes are still privates. They would receive more consideration and more respect from patients if they had some rank.

Physical Education - Class 1 and 2. (2 officers, MAC, 1 Tech. Sgt. qualified in physical education, plus 2 Sgts.) One of these officers should be utilized in the administration of the Class 1 and 2 groups as Commanding Officer. He should be responsible for all activities of the groups and with the necessary liaison with the hospital professional services.

One officer should be utilized as his assistant. He should conduct a large part of the physical and military training, including orientation and any other activity incident to company training, using overseas officer patients as assistants. One non-commissioned officer should be utilized as acting first sergeant and charged with the conduct of physical education of Classes 1 and 2. The other two NCOs should be utilized as platoon leaders. Overhead personnel, such as company clerk and supply clerk, should be assigned from the hospital Service Unit.

Close liaison with the hospital professional services must be maintained by the assignment of a medical officer, preferably from the orthopedic section, to assist the training officer in the proper classification of patients, to make appropriate notes on clinical records as to the progress of patients, and to render advice as to limitations in exercises applicable to selected cases.

Adequate office space should be provided for the Chief of the Section and overhead office personnel furnished by assignment from the hospital Service Unit.

COL. THORNDIKE: Thank you, Colonel Winn. It is a great pleasure for me to introduce the next speaker who probably needs little introduction as he has carried the burdens of the Reconditioning Division for nine months. Major Barton will talk on "A Program for NP Patients." Major Barton:

MAJOR WALTER E. BARTON

A PROGRAM FOR RECONDITIONING THE NEUROPSYCHIATRIC PATIENT

Last year approximately 167,000 patients with neuropsychiatric disorders were released from the Army with a certificate of disability discharge. Additional thousands were lost to the service thru Section VIII and Section X discharges. Estimates indicate that 33% to 45% of the total CDD's from the service were neuropsychiatric cases. Just how many patients had a history of previous nervous or mental illnesses or emotional disturbances, or how many could have been salvaged through prompt and adquate treatment will never be known. The acute manpower shortage makes it imperative to undertake intensive treatment of certain nervous and mental cases in all station and general hospitals. This is necessary in order to conserve a very important source of manpower.

An erroneous attitude has arisen to the effect that no neuropsychiatric patients should be treated. This is a misinterpretation of directives. For a long time it was thought that admission to neuropsychiatric wards was tantamount to discharge. In order that recoverable patients may be distinguised from others some explanation of the common sources of mental and emotional upsets seems necessary. It is easy to understand how a soldier, fighting in Cassino, might break down mentally under stress of combat. According to news accounts, men fought from living room to the kitchen of a house and if they stepped out into ten yards of open space they were sure to be killed. Very often in such an embattled house they experienced its being shot away stone by stone. Under such stress, continuing day after day without relief, even the most normal person may break down emotionally. Everyone has a breaking point. The dazed and confused man who is buried by a shell may develop an emotional disturbance and become a neuropsychiatric casualty. The man who was "pinned down" by machine gun fire may also develop a nervous illness under distress. Think of the term, "pinned down", as applied to the men on Tarawa Beach. Hour after hour they were compelled to stand in water with only their noses above the waves, gulping and retching salt water while machine gun bullets whizzed overhead. Any attempt to get into a comfortable and tolerable position was certain death. Under such a terrific strain, even the most normal person may develop an emotional disturbance. In other words, the situation may be so terrible that it may induce a nervous illness. Situational mental illnesses, if properly handled, are usually recoverable. Too often we think of the neuropsychiatric patients only as the weak sisters or the fellows who slipped through the screening process. Some, of course, do fall into those categories, but there are other types of cases as well. Insofar as treatment is successful in one group, it is important to make this distinction.

Less than 15% of neuropsychiatric disabilities are of the type commonly associated with the term in the mind of the layman. These are the serious mental disturbances or psychoses. Of these, 50% are acute reaction types, atypical confusion states, from which prompt recovery may be expected with adequate treatment. About 10% are neurological disorders and have no associated mental abnormality. The remaining 75% fall into the group of disorders known as psychoneuroses. More than 1/2 of the latter may be expected to recover with prompt treatment.

In planning a reconditioning program for the neuropsychiatric patient, an understanding of certain primary concepts is essential. The first of these is proper housing. Psychotic patients and prisoners should not be intermingled with others in the neuropsychiatric service. The person who is disturbed emotionally is all too ready to jump to the conclusion that the doctor believes he has already lost his mind. It is something he may greatly fear. Do not lock patients up on closed wards unnecessarily. A real barrier to treatment develops in the resentment engendered unnecessarily by harsh methods. It may be necessary, during the period of evaluation and hospitalization for a few days, to use closed wards. It will also, of course, be necessary to confine on locked wards patients during the acute phases of their illness. Patients are to be placed on open wards if it is at all possible.

In the average Army hospital, if there are six neuropsychiatric wards, we may expect that one or two should be closed locked wards, and one be set aside for the acute admissions. The other three or four wards should be used for reconditioning. There are three neuropsychiatric officers assigned to the service in most hospitals. One of these should devote full time to the reconditioning treatment program. Good attendants who are interested in their work and have a genuine desire to help a mental patient are absolutely essential. Too often the poor attendant, who has not made good on other services, and the misfits are assigned to neuropsychiatric wards. The attitude one has toward the neuropsychiatric patient is fundamental in therapy. The kind attendant, through his attitude and helpfulness, looms large in the success of any treatment program. It is important that there be a nucleus of personnel with experience in the management of the neuropsychiatric patient. The trained attendant may be expected to educate others, who are assigned, in the proper approach and management of emotional problems.

The expectancy of recovery - complete recovery - should permeate the atmosphere of a neuropsychiatric service. The patient should be treated in the same normal manner as one would treat patients suffering from any medical or surgical disorder. They should not be treated as fools or children, or referred to by medical officers and hospital staff as "nuts", "near nuts" or "screw balls". Regretably such terminology is too often heard in hospitals and results in real harm in therapy. Patients on neuropsychiatric wards are suffering from the emotional disturbances of war. These disturbances have proper names by which they should be called. One cannot stress too frequently the fundamental nature of proper attitudes in therapy.

A definite planned program of progressive character is an essential. It is a comfort to the patient to know that the physician has a plan for therapy. Confidence is built in this realization. A neuropsychiatric treatment program and reconditioning vary only in terminology. For years psychiatrists have been using what is now known as reconditioning as a part of the active therapy of the nervous and mental patient. It has also been found that the patient must understand that the planned program is treatment for his disability. He must also realize that he has a share in the responsibility for getting well. His success is dependent upon his ability to follow the program as prescribed.

Important to recovery from a nervous or mental disability is prompt attention by the physician. The initial interview should not be postponed. The first contact with emotional disturbances is all important. The opening interview should be made while the emotional disturbance is still very active and before an adjustment to the hospital has been made. The physician builds confidence in himself through his interviews with the patient and makes it possible for him to assure the patient and to offer him suggestions. In any program for nervous and mental disorders, there is no substitute for psychotherapy. To be sure, many short cuts will be necessary to cover the limitations in personnel. Patient-doctor interviews cannot be displaced. There are many specialized approaches to particular types of mental illness which are important, but they cannot be mentioned within the limitations of this discussion.

Group therapy will be found beneficial in the treatment program. Valuable assistance will be gained from the lectures which have been prepared as guides and published in Medical Technical Bulletin No. 12. In group therapy one may discuss personality development, the development of defenses which normal people build against stresses, how defenses so built often fail and how that failure is expressed in symptoms. One can relate the symptoms so expressed to the body systems such as the nervous system, gastro-intestinal system, cardio-vascular system, etc. Discussion should be encouraged on the part of the patients.

Constructive activity should be prescribed as a part of the reconditioning program for its value in the sublimation of symptoms. The types of activity, with very little change, can be those already outlined in the basic reconditioning program. There are differences only of emphasis. Too

strenuous physical activity should be avoided. Frequently it is found that many patients do not participate wholeheartedly in calisthenics. Similarly, combative games with body contact, especially the more vigorous ones, are avoided. The nervous and mental patient may also cooperate poorly in military drill. The patient will find excuses in his aches and pains for inability to participate. He is, however, drawn more easily into sports and games. The pain in the back which prevented his stooping in calisthenics is no handicap in an exciting game of basket ball. Physical reconditioning may be introduced through games and sports. Soon the patient realizes, without his being told so, or his attention being called to the fact, that his disability no longer troubles him so greatly. The sports, games, grass drills, and assigned general work activities are usually accepted.

Occupational therapy plays a more important role in the reconditioning of a nervous and mental patient than in any other group. In the term, occupational therapy, one should include an extension beyond art work and handicraft to all occupational activities that may be prescribed for their therapeutic benefit. What is known as occupational therapy merges into industrial therapy. There are many opportunities for work assignments around the hospital which make it possible for patients to work at specific tasks that are usually assigned only to duty personnel. In this group fall work out of doors on the grounds, landscaping, gardening, work in utilities, maintenance and in offices. This is not to minimize the value of other types of occupational therapy as well. Art work, music, drama and the educational program also have increased in value in therapy to the nervous and mental patient. In recreation, one plans to develop group participation rather than passive observation of movies and entertainers.

The NP patient will profit if he can be put back into a duty uniform. Anything that diminishes the feeling that he is sick is helpful. There is too much inclination to sympathize and to over-examine the emotionally disturbed patient. He is usually quite willing to accept sympathy and seeks for evidences of organic proofs of his discomfort. Wearing a duty uniform is one small but important step of taking away the implication of illness.

Another point of importance in the reconditioning of patients with nervous and mental disorders is the proper reclassification and assignment upon return to duty. There is a sense of security to be gained from the knowledge that even in so vast an organization as the Army proper use of one's skills and talents can be made. A valuable step in this direction has been achieved through WD Circular No. 100, dated 3 March 1944. Section 3 of this circular prescribes a form for the description of patient's disabilities which may be forwarded to the line officer and may serve as a guide in reclassification.

At the present time, there are several experimental set-ups developing a reconditioning process for NP patients. In the Second Service Command, the England General Hospital has a reconditioning section where the NP patient in Classes 1 and 2 may be specially processed and handled. When it is certain that he may be expected to return to duty as a Class 1 patient, he is transferred to the general group of reconditioning trainees and his identity as an NP patient lost. Three Replacement Training Centers are also operating a special program. These are Camp Lee for the Quartermaster Corps, Aberdeen Proving Ground for Ordnance, and Fort Belvoir for the Engineer Corps. Patients convalescent from NP wards are sent to one of these three centers from hospitals. At the center reclassification is made on the basis of training, experience, interests and the limitations induced by his illness. Trainees are assigned to some of the following courses: clerks, bakers, welders, truck drivers, mechanics, instrument repair work, refrigeration, gun repair, train operators, mess and others. It was at first thought that persons with emotional disturbances might

require a slower rate of school training. It was, however, found that usually most men can continue at the same speed. Preliminary estimates indicate that from 40% to 90% of the patients sent to these replacement centers may be successfully returned to duty. In other words, it is possible to take men who have suffered an emotional breakdown in one assignment and after a period of initial treatment to screen them, resurvey them, and place them in new retraining assignments.

It is necessary at this time to emphasize the importance of a treatment program for nervous and mental cases and to expand the reconditioning program to meet their particular needs. The Medical Department has under consideration now a plan which greatly extends the type of activities that have been described in this discussion. In the proposal under consideration, when a patient is received at the evacuation hospital from overseas he will appear before a screening board that may send him to one of four different places. About 10% may be expected to return directly to duty. Some patients, by the time they reach the evacuation hospital, have completely recovered from their emotional upsets. Hospitalization is quite unnecessary, in fact it can do an actual harm. It may be expected that 10% would require no hospital care other than the initial classification and screening process. Secondly, about 20% will be found who are obviously unfit for further service. These will include the serious mental cases and those with a poor history. These are to be sent to designated general hospitals which have provisions for nervous and mental cases. The general hospital may discharge those which do not respond to treatment. Thirdly, about 50% of the patients received in the evacuation hospital for initial screening may go directly to the reconditioning units of a general hospital - the advanced reconditioning section or the NP reconditioning section. Many of this group may be expected to be able to return to duty after such treatment. Fourthly, about 20% of the patients received may be expected to go directly to a Replacement Training Center. Here it would be anticipated that probably 20% would be unable to adjust. These would be sent to the station hospital for discharge from the service. About 80% of the group, however, might be expected to be retrained for further duty assignments. It is to be understood that these figures are only rough estimates based upon the results to date in the trials now under way.

In the attack on the important problem of NP disability, the Medical Department has placed great emphasis upon prevention. Greater care has been taken at the induction point to eliminate the unfit and those likely to break down under stress. Psychiatrists have been assigned to divisions in order that early problems of maladjustment may be detected and also to assist line officers in the prevention of emotional disturbances through his contacts. Replacement Training Centers have established mental health clinics for the treatment of early emotional disturbances, for education of personnel, and for screening. Experience has shown that intensive treatment at the front results in a high proportion of successful cures from emotional disturbances. It is reported that from 60% to 80% may be returned to duty overseas without evacuation. The planned expansion in reconditioning of the NP patient is aimed at those who develop mental and emotional disturbances in this country or who are evacuated from overseas. It is hoped that by screening at the receiving point many can be kept out of hospitals; that others will require but short periods of observation, and that most, through reconditioning and reclassification, may be returned to duty. Under such a plan, it might be expected that the nervous and mental patient will have a much better chance of recovery than he has had up to now.

COLONEL THORNDIKE: Thank you, Major Barton. Now, we will call on Major Johnson who has had very wide experience on the subject "Planning for the CDD." Major Johnson.

MAJOR E. G. JOHNSON

Planning for the CDD patient is a problem that presents many puzzling situations. A number of agencies have been set up to, or are assisting in, this very important social problem -- Chaplain, Red Cross, United States Unemployment Service, Veterans Administration, Army Emergency Relief, Re-employment Committeman of Local Selective Service Board, Vocational Rehabilitation and Training Division of Federal Security Agency, Legal Assistance Officer, and Personal Relations Branch. From what I have been able to learn, the perfect solution for all has yet to be found -- certain cases, a large number apparently, have been satisfactorily handled. The actual solution of each individual problem; of course, is eventually in the realm of these several social agencies, the Veterans Administration, and the individual himself.

It is, in its basic concept, a problem of readjustment to civilian life. One doesn't suddenly become adjusted to civilian life the minute he receives his discharge certificate. Here too, it is necessary to prepare one's mind for a new way of life and frequently with the knowledge and sudden realization that physically or mentally all is not just as it used to seem. It is a strange world to which the CDD returns -- perhaps because it has changed and partially because his view point has changed. Somehow, somewhere during hospitalization, by some person or persons it is necessary to aid this man in his readjustment.

The logical answer seems to be that this prospective CDD should be placed in with others of like nature and there the entire group prepared for the transition. A program of physical activity and conditioning, academic training if indicated, occupational therapy -- especially designed to provide means of vocational sampling when available, recreation, talks by representatives of the social agencies, group therapy for the physically unfit, as well as the NP cases, special rehabilitation for the partially or completely disabled in the various centers specializing in such cases -- all of these have definite value and should be started as early as possible. We have been using some of the methods, in part or in whole. Certain events transpired which made the effective utilization of a CDD ward impracticable. The pressure of more effective utilization of manpower, the reduction in CDD's -- the speed up system in processing CDD's after the final decision had been made by the board, combined with the fact that the greatest percent of CDD ward patients leave the hospital within three days of the final board proceedings. The straight CDD ward was discontinued to reduce a needless administrative burden.

The planned expansion in neuropsychiatric reconditioning stresses the importance of preventing, at division levels, anticipated emotional disturbances to insure proper handling of the soldier. In order to prevent nervous disability at Replacement Training Centers there must be a proper screening of emotional problem people. Secondly, there must be intensive treatment in the front lines. We have seen statistics coming back to us from overseas, that, with prompt care, 60% to 80% are returning to duty overseas without evacuation. Those who are returned to the zone of the interior can be screened at the receiving point so that they will not stay in hospital for additional observation as neuropsychiatric patients really require very little in the way of active treatment. I hope that under such a plan the nervous and mental patient will have a very better chance of recovery than he has had up to now.

COLONEL THORNDIKE: Thank you, Major Barton. Now, we will call on Major Johnson who has had very wide experience on the subject "Planning for the CDD." Major Johnson.

MAJOR E. G. JOHNSON

Planning for the CDD patient is a problem that presents many puzzling situations. A number of agencies have been set up to, or are assisting in, this very important social problem — Chaplain, Red Cross, United States Unemployment Service, Veterans Administration, Army Emergency Relief, Reemployment Committeman of Local Selective Service Board, Vocational Rehabilitation and Training Division of Federal Security Agency, Legal Assistance Officer, and Personal Relations Branch. From what I have been able to learn, the perfect solution for all has yet to be found — certain cases, a large number apparently, have been satisfactorily handled. The actual solution of each individual problem, of course, is eventually in the realm of these several social agencies, the Veterans Administration, and the individual himself.

It is, in its basic concept, a problem of readjustment to civilian life. One doesn't suddenly become adjusted to civilian life the minute he receives his discharge certificate. Here too, it is necessary to prepare one's mind for a new way of life and frequently with the knowledge and sudden realization that physically or mentally all is not just as it used to seem. It is a strange world to which the CDD returns -- perhaps because it has changed and partially because his view point has changed. Somehow, somewhere during hospitalization, by some person or persons it is necessary to aid this man in his readjustment.

The logical answer seems to be that this prospective CDD should be placed in with others of like nature and there the entire group prepared for the transition. A program of physical activity and conditioning, academic training if indicated, occupational therapy -- especially designed to provide means of vocational sampling when available, recreation, talks by representatives of the social agencies, group therapy for the physically unfit, as well as the NP cases, special rehabilitation for the partially or completely disabled in the various centers specializing in such cases -- all of these have definite value and should be started as early as possible. We have been using some of the methods, in part or in whole. Certain events transpired which made the effective utilization of a CDD ward impracticable. The pressure of more effective utilization of manpower, the reduction in CDD's — the speed up system in processing CDD's after the final decision had been made by the board, combined with the fact that the greatest percent of CDD ward patients leave the hospital within three days of the final board proceedings. The straight CDD ward was discontinued to reduce a needless administrative burden.

This was a little disconcerting and the possibility of lengthening the administrative days for this processing was discussed but not considered advisable. Of course, it is known before a patient is boarded that he may be discharged, but for the sake of the morale of those probable CDD's who later are decided capable of useful service, it does not seem advisable to assume too much and thus cause confusion and thereby instill seeds of dissatisfaction. I shall come back to this local problem later.

The group approach may, in some instances, be utilized in NP cases but here also, even more perhaps than in other cases, the "mild" case, if he is going to be of value, should begin as early as possible to make up his mind that he is going back to duty and do a good job of being a soldier. The local situation must be studied. In many sections it may very well be determined that the war officer in his contacts with the NP patient is afforded the best opportunity to begin this re-education. It may require a little missionary work on someone's part but the end is justified. Group therapy must be cautiously applied to avoid instilling dissatisfaction and dissent.

The streamlined system evolved at this hospital for processing CDD patients has been adopted by the SGO and a directive that it be used in all Army hositals has been promulgated to all Service Commands. Therefore, the problem to be brought out now will in the future be met by other reconditioning programs. For a moment I shall discuss the system of CDD proceedings at this hospital. The usual notice is given to the Registrar by Ward Office and the information and names then listed and in turn sent to the Red Cross and Veterans Administration Representative. The man goes before the Board and when CDD is decided, leaves the board and is immediately sent to the Representative of the Veterans Administration for discussion of his problems -- insurance, pension claims, etc. He is sent from there to the Discharge Section of the Military Personnel Branch where his WD AGO Form 53 is completed. Next, he sees the U.S. Employment Representative where the usual processing occurs, then to the Red Cross. The following day he returns, with other CDD patients (to be CDD'd) to visit the Veterans Administration Representatives and any questions are taken up for discussion and unfinished business attended to at once. He is also being cleared administratively and in three days he is out. Not much time for processing! Incidentally, if the Board has any question in its mind as to whether or not the man can be of use to the service in any capacity he is sent to the Classification Officer (of the Adjutant General's Department Branch) and expert advice is secured. Thus the routine CDD case has little chance for group discussion. Our planning for this type of case has evolved into a system of checking with the various agencies to determine several pertinent facts at about two or three weekly intervals -- i.e., do the patients know the nature of their illness or injury and the limitations; are they being informed of their rights, etc.

All these agencies are given time on our lecture program periodically to talk about their duties and how they can help patients in the Army and also how those leaving the Army may be helped. This is a very strong morale factor for the average patient going back to duty and for the patient who suspects that he may be CDD'd presents him with the agencies through which he will be aided in readjustment.

The long term CDD or patient who is known to be certain CDD material is handled by the Red Cross through the social workers. Information of their problems get to the Red Cross in several ways, (1) from the Ward Officer (2) from the "ward leaders", (3) Grey Ladies and (4) frequently from the patient himself because so many of them have family problems or social readjustments which come directly to the attention of the Red Cross or the Chaplain who in appropriate cases refers them to the Red Cross.

Since the Ward Leaders make out the questionnaire on each patient and learn his story and then consult the Ward Officer as to physical classification and probable disposition and date, frequently the problem comes to the attention of the educational officer and active planning is instituted from several angles. Our study exhibit in the library on "Your Future Job" gets the attention of many patients who subsequently come to the educational officer for advice. This type of case almost invariably knows his probable disposition long in advance and has considerable time to think about the future. Key individuals must be made conscious of this problem and pass the information along to the proper persons.

On our weekly tours of which we have from two to three, in the various industrial plants in Clinton, 50% of those participating are CDD patients or probable CDD patients. That is giving some of them, at least, an opportunity to observe civilian workers and to begin thinking along the line of a civilian job. Lectures are given in the afternoon - a series by various industrial and civic leaders in the community - a local judge, highschool teacher, superintendent of a war plant, etc. Whereas every patient to be returned to civilian life may not be included in these tours, discussion is created on certain points and brought up in local ward "bull sessions" (and serve a useful purpose). In the NP wards, especially, films of vocational guidance nature have been secured through the visual aids departments of nearby universities.....handtools, machineshop work, mining, lumbering industry, etc.

In conclusion, planning for the CDD one may break it down in three classifications:

1. The cripple or disabled from blindness, deafness, amputation, etc., who can be cared for by:

   a. Education.
   b. Occupational therapy and vocational training.
   c. Special centers for their respective disability.

2. The long term CDD who requires considerable time for maximum hospital benefit:

   a. It can be planned for by thorough training.
   b. Early notification of auxiliary services by any satisfactory system.
   c. And finally Education - formal, lectures, tours group, talks and vocational therapy where indicated.

3. For the short term CDD it is essential that an efficient system is set up for the operation of the ancillary services.

COLONEL LYNCH: Colonel Thorndike, I would like to inject a few remarks with particular respect to CDD's.

Major Johnson brought up several points which I thought I might clarify particularly with regard to the views of the War Department. With respect to the coordination of the information as to the re-employment and rehabilitation of veterans in connection with the War Manpower Commission and the Selective Service System and numerous other agencies, the President appointed an In-Service rehabilitation committee which operates on the level of the various executive agencies concerned. At the present time the War Manpower Commission is operating several veterans' demonstration centers. The Second Service Command is cooperating in that, as a part of an overall study being made by the ASF in connection with discharge procedures. As a result of the experiences obtained in the operation of

those centers, more concrete and specific instructions should issue before the problem of CDD's builds up to an extent that it may make our present system unworkable. It is the personal interest of the Chief of Staff that no battle-wounded man who has been disabled as the result of a wound received in battle be discharged if he can render useful service in the Army. Accordingly before you CDD a battle-wounded man -- if he wishes to stay on -- providing he can render useful service, he will be sent to one of the three War Department reassignment centers and a determination made at that point. This is somewhat of a departure from our CDD policy and you will find this change in W.D. Circular 293 which was included in Circular 100, I believe.

However, under Circular 293, a man who can render useful service would not be CDD'd so you will find in the circular the exception appears that a man who has been disabled as a result of a combat wound will be CDD'd if he so desires. The point is that the Chief of Staff is personally interested in seeing that those men are allowed to stay on if they want to and if they are usable.

Now as regards CDD, the matter of introducing the fact that he is about to be CDD'd to the enlisted patient in the hospital has been a matter of concern to quite a few officers on the staff. We have discussed it with the officer in charge of rehabilitation in the Marine Corps Staff and also with several in the Bureau of Medicine and Surgery in the Navy.

From the time we bring a man into the service until he gets into the hospital a soldier is under the guidance, command, and control of officers and non-commissioned officers. In many instances we have found, in general and in station hospitals -- in making staff visits -- that the patient learns he is to be discharged on a CDD by various devious and remote means, sometimes the Red Cross Director makes the initial step to advise him as to his rights as a veteran. We think that there should be a specific military procedure; preferably the news should be broken to the patient by an officer who would then make the necessary provision to have the advisors; either the Red Cross, Veteran's Administration, U.S. Employment Service, or those available to the hospital or other facility take the man over and give him specific specialized advice as to what he can expect and do as a veteran. In other words, the initial step we feel should be made as a military job and handled by an officer. As to the technique of procedure, I am not competent to go into details. I will leave that to some of you who are much more familiar with the details but from our point of view on the staff, we feel that it is essential that the initial contact be made on the command level, that is, as an officer to an enlisted man.

Army Service Forces are working on a pamphlet which will coordinate and combine all of the facilities available to the discharged veteran. It is an information pamphlet. Action on it was started some months ago and was suspended but it has been revived and is being worked on. I do not know the status of that pamphlet but it is another step under way in connection with the discharge procedure.

COLONEL THORNDIKE: Thank you, Colonel Lynch. Do I understand that we are to proceed at once and have the officer give that information to the CDD patient?

COLONEL LYNCH: Well, there has never been any standardized procedure we could find, but we feel that it would certainly be the soundest approach rather than to have the man learn by rumor that he is to be discharged. He should be brought in and talked to and that is the opportunity that the officer has to get over the fact that he is still a useful citizen; that the training he has had in the army, in spite of the fact that he has been disabled, will make him a better citizen; that he can go back and do a job. It is important to his mental attitude to be convinced.

BRIG GEN HILLMAN: I think part of that is the Ward Officer's job.

COLONEL THORNDIKE: I think the officer has not finished his job until he has done that. It is the duty of the administrative officer to do his job and not rely on the Red Cross or anything else to inform him.

We come now to the final paper of the evening, "Disciplinary Problems and Their Management." Colonel Winn.

COLONEL WINN: General Hillman, Colonel Thorndike, and Guests.

I feel almost like apologizing for being up here so often but I had nothing to do with it myself -- I am rather being picked on. Before I start my discussion on this problem, I woulk like to express myself on this CDD problem.

I have been an officer assisting in surgical wards in general hospitals and large station hospitals throughout my army career. I have never discharged a man or recommended a discharge for CDD without talking to the man personally and going over all his problems with him. That is part of your duty as a ward officer, and I don't quite understand how the impression has gotten out that the soldier is not informed by an officer that he is going to be CDD'd. Of course, he is informed by a CDD Board when he appears before it and he realizes the Board is carried on in a dignified manner and with an interest in the soldier as well as an obligation to the government. This Board always tells the man what the story is and, in this hospital, the Veteran's Bureau contacts the man within five minutes after he leaves that Board and his processing as to his rights and privileges begins right there. I don't believe the patients in this hospital have had that complaint.

Now as regards disciplinary problems.

A hospital is a military installation. There is the same necessity for military discipline that there is in a company or squadron. The disciplinary problems in a general hospital are such that it is difficult to discuss them in connection with the Reconditioning Program per se.

In the class 1 and 2 group, which is conducted as a convalescent detachment and in much the same manner as a company or similar unit is administered, the disciplinary problems are little different from those ordinarily encountered in such units. They consist chiefly of absence without leave, overstaying of passes, occasional drunkenness and disorderly conduct, and lack of cooperation (goldbricking). Every effort is made to produce and maintain a high state of morale among this group. When a patient first enters the group, he is given a copy of the rules to which he is to conform and the privileges he may enjoy. The Commanding Officer of the detachment explains these things in an interview with the man who is made to understand that there is a Commanding Officer. The purpose of the program, as outlined in Circular Letter No. 293, SGO, is explained to him in an effort to make him clearly understand what we are trying to accomplish. Passes after duty hours are given more liberally than to ward patients. Ordinarily a man gets a pass twice a week from 1600 to 2300 and on Saturday from 1300 to 0100 Sunday. About every other week a weekend pass from 1300 Saturday to 2300 Sunday may be given if the soldier has a special place to go. Passes are denied for breaches of discipline. A company punishment record is maintained. However, reprimand, admonition, and company punishment are utilized to the fullest extent and are usually sufficient. For serious breaches of discipline patients are tried by summary court, sentences being limited to restrictions and fines.

It has been a common experience to note a distinct change for the better in the soldier's attitude towards his treatment, as well as his zeal for service, following his transfer from hospital environment. The change usually begins when he dicards his hospital clothing and resumes the uniform. Little trouble is encountered by lack of cooperation. The soldier usually eventually falls in line when he finds himself out of step with the spirit of his comrades.

Disciplinary problems of Class 3 and 4, of course, are those common to all hospitals whether a Reconditioning Program is conducted or not. There are a few patients who refuse to participate in the Reconditioning Program. This sales resistance is usually overcome by the proper sort of persuasion. Limitation of passes and extra ward fatigue may be necessary. This problem is usually handled by the administrative ward officer. Failure to report for scheduled activities is a constantly recurring problem. Its incidence is directly in proportion to the degree of organization of the Reconditioning Program. It is combatted by encouraging increased cooperation on the part of ward personnel and by limitation of privileges. It may be considered an index of the efficiency of the ward officer and administrative ward officer. Absence without leave is an ever present problem. Its incidence varies from time to time and it is influence by the type of patients making up the several convoys. It usually occurs in patients who have been given passes, although there have been occasions when patients secured their clothing through lax ward administration. Restriction of privileges and company punishment by the Commanding Officer, Detachment of Patients, has not been markedly effectual. Trial by summary court is resorted to in the case of chronic offenders. If the habit of going AWOL or being guilty of drunkenness is interfering with the proper treatment of a patient, measures are provided to transfer him to the enforced treatment ward where, of course, no privileges are extended. Overstaying of passes is a fairly common problem.

Company punishment and limitation of privileges do not have the salutary effect which might be expected in an organization with a stable personnel. There are occasional cases of drunkenness. The sale of beer on the Post is limited to individuals in uniform. The introduction of alcoholic liquors to the hospital is carefully watched, but measures adopted so far have not been completely successful. Practically all of the drunkenness occurs in patients while on pass. This occurs in spite of the efforts of the authorities in this community to limit the sale of whiskey to men in uniform.

Many measures are taken at this hospital to orient the patient and improve his morale. Participation in the reconditioning program is one of the most important. While I have no exact figures to quote, it is the concensus of those concerned with the question that disciplinary problems have definitely decreased as a result of the reconditioning program. I don't think there can be any doubt about it

Upon admission to the hospital each patient is furnished a mimeographed information sheet explaining the policy of this hospital on the granting of passes and furloughs. This is one of the most important things in the soldier's mind when he comes to this hospital, "When can I get a furlough?" In addition to this, the same subject is explained by an administrative officer to groups of patients received in convoys as soon as they are admitted to the receiving section.

Machinery has been set up to insure the prompt payment of patients. We have patients in this hospital who haven't been paid for months when they arrived here. We pay them.

An informative booklet, which has been put on your desk donated by the Northwestern Bell Telephone Co., giving information about the hospital and the community, which we hope will help the morale a little.

The Telephone Company has provided, at its own expense, a telephone center with full time employees where patients may conveniently obtain proper change and where they may sit comfortably while awaiting long distance telephone connections. In addition to this, each ward has been wired so that it is possible for any bedridden patient to use the long distance telephone at any hour. This has proven an excellent morale factor and one which is frequently commented upon by patients. I mention this because they are some of the reasons perhaps why disciplinary problems are decreasing.

Through the courtesy of B'nai B'rith of Iowa there is now being installed throughout the hospital a centrally controlled radio system. It will be completed around the first of April. When completed, this system will make it possible to transmit to the wards programs carried on in the Red Cross Auditorium, selected recorded music, and such radio programs as may be selected.

It is believed that all of the foregoing activities will strengthen morale and reduce disciplinary problems.

There is another problem which might well be discussed at this time. It borders on some of the remakrs which have just been made by previous speakers. As increasing numbers of overseas casualties are admitted to general hospitals, there is a necessity for a more flexible concept with respect to disciplinary management of hospital cases. During the past six weeks approximately 500 overseas cases have been admitted to this hospital. Approximately 85 percent of these cases were either convalescing or had completely recovered from the disability which required their evacuation. A considerable number of these patients were either misinformed or misinterpreted information with respect to present policies regarding transfer to general hospitals in the vicinity of their homes. They were likewise misinformed at some place along the evacuation line of their furlough privileges. Most of them expected to be given a 30 day overseas furlough immediately upon their arrival at this hospital, because, they stated, they had been assured at previous stops that this would be done. One can easily imagine the effect of such a state of affairs on the general morale of the hospital. At a panel discussion held shortly after we received a convoy, a patient asked this question, although it was entirely irrevelant to the meeting: "Why do our doctors lie to us about furloughs?" He then explained that he had been assured at the time of his evacuation from overseas that he would receive a 30 day overseas furlough immediately upon reaching a general hospital in this country; that he was again assured by the transferring general hospital that he would receive the furlough as soon as he reached this hospital. Of course this hospital does not grant overseas furloughs, even after a man's treatment is completed and he proceeds to his reassignment station. I think it would be a good thing if we were allowed to give these furloughs. You assign a man to a reassignment station - say he lives in Oregon and is stationed in New York - he has to pay his fare all the way from New York to Oregon and back. An officer patient who was participating in the program and who arrived with the same convoy volunteered to answer this question and satisfied the soldier by explaining existing policies and the reasons for misunderstandings. The practice of disseminating this type of incorrect information should be discontinued. The soldier's chief concern is when a furlough can be given him. He is much less concerned about getting well. Because of the necessity of working up and evaluating the case, it has been our policy not to grant passes during the first seven days in the hospital. This allows the war officer time to work all of the cases up even when a large convoy is admitted. Many patients telephone their families as soon as they arrive and the families promptly entrain for Clinton.

The patient insists that he be given a pass to spend with his relatives. Recently an officer went AWOL from this hospital stating upon his return that he was sure a request for a pass would be refused and therefore knowingly committed this breach of discipline. When enlisted men hear of such conduct on the part of officers, the disciplinary problem for the hospital becomes most difficult. Most of these difficulties are due to the fact that the patient upon arrival at the general hospital is not in a true sense a general hospital case. The same personnel and facilities which are designed to process and treat the injured and sick are required to process these cases. This is time consuming and wasteful of facilities which are needed for the purposes for which they were designed. Ward officers cannot ascertain merely by a casual inspection whether a patient should remain in a hospital or whether he should be returned to duty. It is necessary to work the case up, evaluate and make a decision as to disposition. It is believed that these difficulties will increase as time goes on and that consideration should be given to the advisability of establishing large convalescent centers for the direct admission of overseas casualties by transfer from ports of debarkation. General hospital personnel thus would be spared the time consuming efforts involved in processing non-general hospital cases.

Our own policy on the furlough is this; if a man has been here a week and we have had time to evaluate him, and providing his ward officer recommends it, and providing he is probably going to have a prolonged hospitalization, he is given a seven day furlough plus travel time. Call it what you want; it isn't sick furlough, it isn't overseas furlough, and we don't give ordinary furloughs. This is a psychological furlough. He gets his furlough, his morale is much better and he comes back and we have less trouble in handling him. Thank you very much.

COL. THORNDIKE: Thank you Colonel Winn. That closes the program for the day. We have had a very long day and I wish to call your attention to the hour and to the fact that the program was completed five minutes ahead of time. Colonel Winn, we thank you very much for the efficient way you have taken us around today very much on schedule. It was very interesting.

End of Part One

COLONEL AUGUSTUS THORNDIKE

Will the meeting please come to order? This morning's program is divided into two sections -- the Physical Fitness Program and the Educational Reconditioning Program. I hope everyone will participate in this discussion as I believe it is important that we have a free exchange of ideas. The first speaker is Dr. C. H. McCloy, Professor of Physical Education at the State University of Iowa. He is the consultant in physical training to The Surgeon General. His subject is, "Physical Fitness Program". Dr. McCloy.

DOCTOR C. H. McCLOY

Very obviously, physical fitness is not the only aspect of the total fitness of a soldier. I think that that is one of the things of which we need to remind ourselves occasionally. Because of the fact that the physical fitness program occupies such a large part in the reconditioning of the soldier in our hospitals, all too frequently it is looked upon as being the one major thing. Actually, to recondition a man to go back and be the most effective soldier, his mental, his emotional, and his military reconditioning are just as important.

As far as the Physical Reconditioning Program is concerned, we are not too much worried by the minor ills we find in hospitals. The man who is going to be at the station hospital for only four or five days does not usually need to go through very much of a reconditioning program before he goes back to duty. He recovers very quickly and usually has relatively little residual weakness.

I want to take up a number of major points. In the case of surgery, I think that most physicians and surgeons do not realize how much heavy work an individual can do almost immediately after an operation. We see bed exercises in most of our hospitals as a rather gentle procedure. Let us take the case of an individual who has been operated for hernia. He has an injury caused by the operation but all the rest of his body is just as sound as it was before he was operated. A great deal of the feeling of prostration and that sort of thing exhibited by the man, is emotional. Part of it is a sympathetic response which can be rather readily controlled, but he has been so accustomed in civilian life to thinking of himself as an invalid when he goes into the hospital -- he possibly was frightened before he was operated, and the emotional effect of that fright has affected his sympathetic responses -- that he feels prostrated. But there is no reason in the world why that man can't do pretty heavy exercise with the parts of the body not concerned with the operation.

I am going to succumb to the temptation to tell you one piece of personal experience to show you that I am not just an optimist and not just talking out of non-medical experience and theory. I was operated for a double hernia about four years ago at an age quite a bit past the time you are getting these soldiers in the hospital. My surgeon insisted that I stay in bed for three weeks, which I did. With his permission, however, at the end of the second day, I began to take workouts in bed much more strenuous than you saw in the gymnasium yesterday. I did three thirty-five minute workouts a day, using largely tension exercises because I had no dumbbells or other equipment but simply worked one muscle group against the other. I worked as hard as I would have worked had I been lifting weights. I worked everything but my abdominal muscles. I even "bridged" on my head and feet, with my knees straight. Any of you who has tried this know that it is a rather severe strain on the back muscles. At the end of three weeks I was stronger muscularly than when I went to bed. I got out of bed at the end of three weeks and had no unpleasant symptoms, though I had not even been out of bed to to to the bathroom; I obeyed my doctor. I wasn't dizzy; and I had none of the usual symptoms of post-operative weakness. I then went out in the yard and did a half-hour's workout about like the one in TC 87.

Then I took a five-mile hike over the golf course, shot two hours of archery, walked another mile back home, and felt fine. There I was, three weeks in bed without getting up at all, and I didn't even have sympathetic disturbances when I did get up. The point is that the man who has been operated can work the non-injured parts of his body just as well as if he were a well man.

One important function of this type of bed exercise is to combat the feeling that a man is an invalid. I am quite sure that if we start with these men in such a way, that they will never get the feeling that they are in a hospital; at least those who are not too badly shot up, old cripples or too badly disabled. We should get them to feel that, "Well, now I have this arm, this leg, or this shoulder broken, I have been operated for a hernia or had an appendectomy, or whatever it is, but the rest of me is all right." In the Army one should not consider himself an invalid. I believe I may have emphasized this a little too strongly, perhaps, but one of the functions of this program is to cause a man never to think of himself as a person who is badly incapacitated all over, and consequently, the program should be strenuous enough in bed, at the beginning, and should so continue when he gets out of bed, so that he will have maintained his physical condition.

The kind of bed exercises we usually see will not maintain a man in condition. He will continue to slip and I will tell you why. The reason why he continues to slip is because of the fact that if we wish to maintain physical condition, we must make a physical demand at least as great as we have been commonly making simply to maintain condition. If you want to improve, you must make a physical demand greater than has been your custom Let me illustrate. Suppose I wanted to develop a considerable amount of muscle in my arm -- I wanted to get to look like Charles Atlas! I could take a one-pound dumbbell and exercise with it every day. I would gain some muscular endurance. It has been found that in prolonged exercise of that kind the vascular system has an increase of about fifty per cent in the number of capillaries; but I would gain no particular strength because I already have much more than enough strength to handle a one-pound dumbbell, and I would be making no demand which is in excess of what I am already constantly doing. If I used a thirty-five pound dumbbell, the result would be very different. At present I happen to know I can lift it only about five times with my left arm before having to stop. I would use it each day until I could lift it a dozen times. I would then take a forty-pound dumbbell, then a forty-five-pound dumbbell and lift it each day and one could almost see the muscular growth, for I am making a demand in excess of my common demand. If I continue to make a demand less than my common demand, I will retrogress.

Another illustration of this. All of you are sufficiently acquainted with school athletics to know this to be true. Suppose a track man wanted to be able to run a mile in 4:20. He could run a mile in ten minutes every day for ten years and still he couldn't run one in six. He has to run regularly until it hurts. He has to make much more demand than he has been making before; then, when he gets up to that demand, he demands a little more and a little more -- that is the way in which he gains. If one simply continues the demands he has been making, he maintains his physical status. If he makes an increased demand to improve it, there isn't any reason why he, or for that matter, any man coming to us in this hospital, can't be improved a good deal because the Army doesn't always turn them over to us in too good condition This is called the "over-load" principle. This is an unfortunate term. It is not an over-load in a real sense - it is an over-load beyond what one has been accustomed to carrying.

The next thing in any physical development program is that we need to have the program progressively built-up -- a little more this week and a little more next week.

In order to implement this over-load principle, we must classify these men.. For example, let us take Class III patients to make it simple. We may have patients in Class III A, B, or C. The III A's are in just as good shape as the II's except that the III A's are still in the hospital - they are under treatment; the III B's are not quite in such good shape and the III C's are in poor shape.

We can start in with a group of exercises which will last for about ten exercises, and the III C's will then fall out. Another half dozen and the III B's will fall out. The III A's continue doing more of them. After a few days the present C's will continue through the B's exercises and the B's will continue through the A's, making a continuous improvement. Since, in a hospital we have new men coming in all the time, we can't continue simply to increase repetition and cadence, but in Class II when they go up from section to section, we can increase the load. In cases so severe that they have had to slip, for example; the pneumonias of which Colonel Rusk spoke yesterday, or a rather bad surgical case, or where a man is in bed with a broken femur for a long time they will, of course, take much more time. They will have to start much easier but don't let us get our minds set by these relatively few bad cases throughout all the hospitals of the Service Command. They don't make up the majority of the cases: most of the men progress much more rapidly. I just wanted to bring out the fact that one shouldn't rather unintelligently give this program in the somewhat exceptional cases with the severity which I have indicated.

In Orthopedic cases, the general maintenance of the rest of the body is an important thing. It is necessary, in working on this type of disability to employ physio therapy, occupational therapy and bed exercises. When the ward surgeon is convinced that it is justified, and prescribes it, he can keep these men from slipping very much. When they get to improving, they should then work on the part which has been operated. This is the part we have to get back in shape.

In medical cases we have considered the matter of tests, such as cardiovascular tests. I have investigated the present tests - looked up what was written on the subject - and it did not seem to us there was anything which gave promise of enough help to justify putting it in the program, particularly in view of the fact of how busy the staff in the hospital is. I believe the clinical judgment of the physicians, supplemented by such evidence as sedimentation rate, and things of that kind are probably enough. When you get these men to where those in the medical service are willing to let them start in with a physical educational program, they can start sufficiently gently at the beginning. Let us say with the IV C program, he can make progress without overdoing it. I don't think we should do too much with the cardiovascular tests. We can just begin easily and then step it up.

Let me call your attention to one other thing concerning these bed exercises. When you have a man in bed and are working on only one set of muscles at one time, you are not getting the tendency towards prostration that you would get with a man out of condition when he is out of bed. When he is out of bed he is having to carry all the weight of himself. In the second place as you all know, when he gets out of bed the sympathetic control of his splanchnic area is not adequate. He very easily gets a little brain anemia and the splanchnic circulatory system is too much dilated for strenuous exercise, and he tends to feel nauseated. When you have that same man in bed and the blood is flowing in his veins just as freely as before he started exercising, he can take a much bigger dose of exercise on the local muscle groups. These medical cases, even though they can get up and move around the ward, should be kept in the Class IV program - that is, doing most of their exercises in bed - until they get enough splanchnic control to justify their getting up for their exercise. Remember that the Army does not always give you men in good condition. The directive that the Army should get its men in good physical condition is more honored in the breach than in the observance. We have a lot of evidence of that based on tests given to the Army. You are going to get men, some of whom are in excellent condition -- splendid athletes -- and then, again, some individuals who are in terrible condition when they come to you. You have to take that into

account. You can't say, "This man has been in the Army a year and a half and therefore he should be in pretty good shape." It depends very much on the outfit he was in.

Remember that because of the overload principle, you need some exercise that is pretty intense. When you have them in Class IV, you cannot give much intense exercise of the cardio-respiratory type. But you can give very strenuous exercises for the local muscle groups which will strengthen them and will make for real improvement. As soon as you can get him up, and he can begin to take it, put the pressure on for part of the time for endurance of the cardio-respiratory type. The best way to exercise the heart is through the legs. The class drills you saw yesterday for Class II will begin to put that pressure on. You need some time -- not too long -- of relatively intense exercise for this overload to push the strength up. You need a lot more of sub maximal types of exercise such as we saw yesterday, particularly games like volley ball which isn't very strenuous, or other games that aren't too strenuous, for the development of stamina. There is a lot of difference between the athlete who can go out and do an excellent job on a cross country run for twenty minutes and a man who can go out with a lumber jack and do a long hard day's work. One thing is the athlete's ability of a short time nature - the other is stamina that will carry him through a long grind. The soldier needs stamina. He can't quite get it by these half hour or one hour spurts of exercise. The Army has long put emphasis on marching greater distances, carrying full packs. Hence we need some of that for what we call stamina.

Third, you need special exercise for special disabilities. A Nicola operation needs something that will work the shoulder and get its strength back again. Or a leg has become atrophied, and needs special attention. The way to do this is to exercise for the special disability.

If all that were involved was simply to get that man physically in condition, we could do a pretty good job in, say, forty minutes a day of calisthenics and running and a bit of double timing in addition. The Army conducted an experiment at Fort Riley a year and a half ago. Three of us went down there at General McNair's invitation. We tested first one squadron of 256 men who were picked by a census bureau statistician as being a good representative sample of the whole United States population. This group was tested with the physical fitness tests that we developed for the Army at that time, and then they were matched by three times that number from other parts of the fort. We chose another 256 from them who also matched this first 256 in physical fitness scores. These others took their regular physical training which consisted largely of easy calisthenics, and that was about all. We found, in the ground forces, that the calisthenics were then not too well conducted. We timed them in about ten different camps. They averaged about three minutes of rest to thirty seconds of exercise, hence they were not very conditioning. This was about all these people got. This experimental group was given the program which we wrote up for that occasion and which was later adopted as TC 87. This group was tested when they first came to the Replacement Training Center. They were given the program prescribed in TC 87 and in six weeks they had gone up to the point they were in as good condition as the paratroopers were in nine months, tho it pretty nearly killed them for the first two weeks! They only had one hour a day plus a good deal of double timing. If they marched out to the rifle range, they doubled back. Those two things put them into that excellent condition. The only activity other than their regular marching was only an hour a day, but they got that hour a day in well conducted strenuous exercises. In forty to sixty minutes a day you can condition your patients adequately, but it would be a harder grind than they should have, and you need something else. You need some marching. These men are soldiers as well as patients getting reconditioning. They need some fun in addition. They need some games and things of that kind, and a lot of additional sub-maximal activity for stamina.

I should like the advice of some of you people from the standpoint of military effectiveness, of close order drill such as you saw yesterday. Should we have the cripples mixed in with the other men? They can't keep step, and it makes it look awfully sloppy. I wonder if it is good military procedure to conduct this type of training or whether they should be segregated by types. I would like some advice on that before we finally finish this manual on which we are now working. But these patients need discipline; they are in the Army.

The next thing is, there should be considerable stress on the psychological phase of this physical strength program. I have seen a great many men leading this program who tried to drive too hard. You can lead men places that you can't drive them. You need some good old enthusiasm - the old advertising - a person who believes in this program himself, who is himself a good example of fitness - who is so enthusiastic about this fitness that he just pulls the men along. Every time I hear Colonel Rusk talk about this program I just straighten up and my chest gets about an inch bigger. We need spirit. In Halloran General Hospital some of the ward leaders were most enthusiastic about what they were doing. The men would say, "This is a good exercise, fellows". They got in there and went through some of the exercises so sincerely themselves one could just see those patients feeling, "It must be a good exercise or this man wouldn't love it so much". It was a good leadership - good salesmanship. Charles Atlas has a hundred women in New York sending out materials, sixty more in London and sixty more in Buenos Aires. He sells things. There are many scientific fallacies in his presentation; he thinks it is all correct. But he has salesmanship. You read his material and you want to do something. Let us have similar, but scientifically correct salesmanship that can make these men want to do things, not just do them because they are required.

It has to be adapted to the individual. One must have different dosages for the A's, B's and C's. Some will be C's because they came to the hospital in bad condition. Different gymnasium squad projects, work projects and the like will accomplish this. I think we also want to remember that when we get a man into the reconditioning program it doesn't necessarily mean he is in for a four weeks' course. If you can get him out in four days or two weeks, don't think he has to take the full four weeks' course. Many men can graduate from III-A to II-A and then to I-A in two weeks. The courses must be adapted to individual differences.

I will take up these individual activities by classes. I spoke of the matter of dividing Class III and IV patients into A, B and C groups. The IV's can be geared into groups together with III's. What I mean is this: In many hospitals, you do not have the fortunate conditions existing in this hospital, where it is relatively easy to get your III's into the gymnasium. In some cases patients may have to go out of doors to get to the gymnasium, or they may have to go quite a distance. The weather is an important factor and in bad weather you may have to exercise the III's in the wards. Where that is true, you can very readily have exercises for the III's and IV's geared together so the IV's can do approximately the same thing in bed that the III's are doing standing up. This matter will be treated in the manual on this subject which is being prepared. The two groups can be lead at the same time by the same man and have the inspiration of working with a larger group. The III and IV-C's will fall out at the end of a certain number of exercises. That is all they can take. A few days later they will progress to the B group.

In this program for Class IV's, I think one of the things we can begin to teach them is how to relax. A great many of them will meet conditions from then on when relaxation is a very valuable thing. You know how tense we all can get when under strain. We are going to have one small section in the manual to teach people how to relax -- how to let go, how to go to sleep. This is an excellent time to teach it while these men are in bed.

We have spoken of bed exercises. Bed recreation is not too hopeful, I think. We will have to depend to a large extent upon our friends in the Red Cross to keep our men interested and amused. Occupational therapy can do the same thing, but physical recreation in bed is very limited. With the cooperation of some Class III's, the bed patients can do a few things such as pitching rope quoits, etc., but it cannot be a very large part of the program. The main thing is to have the bed exercise programs, plus the mental and emotional therapy supplied by the Red Cross and by Occupational Therapy.

When we have the Class III's out of bed, I think we should begin to stress another thing, and that is better posture. Many of these men have difficulties because of bad foot posture or trouble with their backs. While they are in the hospital, we have time to teach them things along that line. Some of these men should still have some bed exercises because such exercises can be made more intense. They can take a stiffer dosage when they are lying down than when they are standing up just after they are up out of bed.

I will not comment on Class III calisthenics. You all know what calisthenics are. Do them in the gymnasium, if possible, as they are doing here. It gets the men out of the wards, out of the hospital atmosphere. At times you can have the men doing resistance exercises in pairs. These are exercises where one man resists another and this makes it hard to do any goldbricking.

We can have a good many games in the wards. You saw a few samples of that yesterday but there are many other games of some strenuousness which will keep the men busy for quite a while. I hope eventually, through the Red Cross and occupational therapy groups, that every ward will have enough games so that you will not have to move them around the wards on a cart. Then whenever it seems desirable, the games can be brought out and used.

When the III's get out of doors or over to the gymnasium, there are a good many things you can do that you can't do in the wards. If there is nothing else available, you can use the space between two wards for them to play pepper ball, volley ball, deck tennis, fly and bait casting, and lots of other things to keep them busy and get them in condition. In the wards you can also do something which I have seen done best in the station hospital at Camp Crowder. There they bring a cart around once a day to the ward with something like four medicine balls on it (two of those should be rather light). (Incidentally, there is something at Halloran General Hospital I hadn't seen before. They had some full sized medicine balls stuffed with curled hair so that they weighed about three pounds). The carts I mentioned also contained volley balls not pumped up too tightly, four skipping ropes, some iron dumbbells, wooden dumbbells, a few Indian clubs for those who need to exercise their arms and wrists. The men were required to take various exercises with this equipment. It was like a small gymnasium. The cart stayed in the ward half an hour and the men got a lot of good exercise in a much more interesting way than by calisthenics. They also had a couple of these ankle discs such as you saw in Colonel Dively's film yesterday for limbering up and straightening stiff ankles. In this film you also saw the rope back pulls. The men sit on the floor and pull each other. People with abdominal wounds can get back exercise this way and, with the other man pulling forward, they don't strain the abdominal muscles.

These men can go to the gymnasium or get out and hike in good weather if they take it easy, because many of these are in just as good shape as some of the II's except that they are still under medical treatment. Get them into uniform just as quickly as possible.

PROGRAMS FOR CLASSES I and II

In most places we try to divide the I's and II's into A's and B's simply to keep the activities at about the same degree of strenuousness and to obviate the necessity of making too many individual allowances. Get these men away from the hospital as quickly as you can.

I am going to speak of several types of activities.

The first, I will call mass activities - where you can exercise the whole group at once. Calisthenics, of course, is one of that type. You might try a substitute for calisthenics from time to time, as the groups get fed up on the same calisthenics every day. About everyother day, do something else; for example, the guarilla activities. This is sometimes done in circular set-up or in column formation. These are such activities as walking bent over, walking with kicks, and grass drills. The men get a lot of exercise from this. Then there is shadow boxing, and partner boxing (I don't mean where they actually box -- I am not particularly enthusiastic about boxing in the Reconditioning Program because there are too many chances for injury, but they can pair off and learn about footwork and defense). We saw some slides from Halloran of people shadow boxing. Something like that can often take the place of calisthenics and do just as good a job.

The second type is marching and running. Running is one of the best exercises in the world. Professional athletes do a lot of walking and double timing. They refer to it as "road work." In Army parlance, it is marching, with double time used an increasingly large percentage of the time. If they march six miles, they might, at first jog one-half mile in broken doses at double time. This could later be increasedto a mile although not, of course, all at one stretch. There are grass drills, or "wind sprints" as they are sometimes called in football, and relay races. If you use these don't pay too much attention to twenty-yard races in a gymnasium: Put them out of doors where they can run at least one hundred yards. The short races are of little value.

Obstacle courses are excellent. I want to speak about this activity a moment, and we will show some slides when I have finished. I have been through a great many hospitals and talked to patients and asked them how they were hurt. Many of them said they were hurt on obstacle courses. I find in some hospitals, many are getting rehurt on the obstacle courses. They should not be run for speed. Don't let the men race over them. I met one man here in the hospital who was hurt going over an obstacle course in California. He had a broken leg. He said, "I had run that thing a dozen times, but I got careless in going over the wall and fell." He was racing. If possible, build your obstacle course so you have a primary course for your II's and another more difficult one for your I's. Walk them over it slowly at first, teach them how to negotiate it, then have them go over it faster and faster, but don't have them go over it so fast that there is a probability of injury.

Close order drill is just as good a conditioner for Class I and II patients as for the well soldier. They can later graduate into longer marches with packs.

The combative activities, of which you saw a few yesterday, are good. They give back a lot of the old fighting spirit. If a man is defeated by his opponent fifty times and on the fifty-first trial explodes in the opponent's face, he has learned something of value. That type of activity is an excellent one to put in. It works into much tougher exercise than you saw yesterday. Most of that should be done outside on the grass.

Next, about games and athletics. Athletics can be placed in the strenuous type. Basketball is particularly good; speedball is very strenuous also. Then there are other types that are not so strenuous but are good exercise; the fellows get fun out of them and a good deal of action, too. If you have access to a swimming pool as you have here, by all means use it for this work. It is an excellent conditioning Program.

The second general type is what we call group activity, or "small group rotating gymnasium activities". These are usually carried on in an indoor or outdoor gymnasium. Yesterday you saw one example of this that wasn't too complete, not because it wasn't well organized and well planned, but because there wasn't enough equipment. The equipment has been ordered but just hasn't arrived. If the gymnasium is well equipped, it can be much better.

Now about bar bells and heavy dumbbells: Many people seem to have a misconception of weight lifting. All weight lifting isn't the type where you strain everything that you have and over-exert yourself. There is another that is a much better type, where one can stick to the type of lifting that is moderate enough for the man. Have enough repetition - say ten or fifteen repetitions - enough to tire that group of muscles very rapidly. That type will build strength faster than anything I know of. I would guard against the type where the veins stand out and one strains everything he has; that is not as good for our purpose. Spring exercises are very good for certain muscles. Horizontal bars and parallel bars, when properly used, are very good for many excellent developmental activities.

The use of rowing machines, medicine balls and the heavy punching bag provides very strenuous exercise and is particularly good for people getting up into Class I who need to strengthen upper trunk muscles, wrist, shoulders and elbows.

A man is about as old as his abdominal muscles. Feel yourself there and see how old you are! When you get a group of men who are soft in front, they are not in good condition for the Army. Reported surveys have shown that America is soft in the belly.

Tumbling and stunts of various kinds, rope skipping and light bag punching are excellent. For strengthening specific disabilities we have the Indian clubs, shoulder wheel, wrist rollers, finger pullers, bicycles and pulley weights, the knee rockers that are used for leg disabilities, and special calisthenic exercises on the mat. This kind of small group rotating exercises is definitely prescribed. We do not just send the men on a routine march around the gymnasium. With proper prescription of what the man needs, he can be put in a particular group. Somebody has to do a little scheduling, as one has to do in everything else. This type of exercise is one of the finest things to build a man up where he is weak and get him back into good condition. An hour a day in Classes IV, and III and II and three hours a week in Class I is very valuable.

Labor projects: We should guard against thinking that reconditioning patients are just labor battalions. The work should be something that is very definitely planned to bear on the reconditioning of the trainee, the specific reconditioning needs of each individual person. As jobs are available around the hospital, they should be carefully analyzed. What will this job do for any given man? You may find a man setting type. He is not a good typesetter, because he can't set as much type in a day as a good typesetter would set in fifteen minutes - but he has a nerve injury in his hand and he needs that type of work.

The man who is a good printer may be hammering some soles on shoes in the orthopedic shop because he can't get a good grip on a hammer. We give him a hammer with a very large handle and put him on that job because it is the best job for him. If all the tasks are analyzed as to what they will do for them, and the men are distributed to these tasks in accord with their needs, these labor projects are then planned constructively. This is occupational therapy just as much as labor therapy. It is important and should be kept in mind. One should not use work therapy to the exclusion of everything else.

Now, that is in general the major list of subjects I wanted to discuss; but I want to speak of one or two other miscellaneous items. First, the NP patient that Major Barton covered so very comprehensively last night. I have just a couple of observations that I would like to add. One of the things we want to remember is that the physical type of activities, such as athletics and games, etc., go back to the oldest phylogenetic aspects of the organism. Our trunk muscles date as far back as the earth worm; shoulder and arm back from the fish, and the other muscles date as far back as the apes and the monkeys. The nervous system that controls them is very easy to handle as compared with the more recently evolved nerves of higher emotions and intelligence which have often received the greatest impacts in battle exhaustion cases. We want to remember that the simplest fundamental exercise programs are important to people who have these functional upsets in their psychomotor systems. The men in the NP service are agreed that they should get them back into the Army and out of a hospital as rapidly as possible. I have talked to dozens of these men and find that they are often afraid just because they are in a neuropsychiatric ward. They don't believe they are not crazy even though the psychiatrist assures them they aren't. It is important that we get them back in an Army camp where the signs of a hospital are absent.

We need to start those people with a great deal of recreational activities. I was a bit impressed, when at Halloran General Hospital, to see that they are starting those people on ward calisthenics. They go into these activities like anyone else, and they enter into a going routine and absorb it very well. I agree wholeheartedly with Major Barton that we need to emphasize very strongly the recreational and athletic types of activity. Put them in tournaments and activities where there is some competition and motivation behind it. The rest of the program should be about the same as Class I and II but since most of them won't have many other specific disabilities, they won't need much of these special rotating group exercises.

I am not going to discuss the personnel that we need because that is being cared for by the proper authorities, but I do want to stress the utilization of what we have available. I am going to tell you a little story. I was in a goup making a study of physical education and after a certain length of time I was sitting at the table with the senior officers. An officer of the group said to me "Dr. McCloy, I suppose by this time you have found that there isn't much you can do here in physical training." I said, "To the contrary, there is a lot you can do. There is one impression I have gained here and that is, I have never seen a group of men of such high intelligence that can find so many reasons why things can't be done." I hastened to add that it wasn't any reflection on their intelligence but it was a new thing and that every man there would have to spend much time revising his schedules to take care of the work and they did not relish the prospect.

I think that same mental attitude sometimes creeps into a hospital when a program is new and inconvenient to schedule. People have a tendency to think up reasons why it can't be done rather than say "This thing is going to be done. Let us find ways to do it." I was told at the beginning that ward masters could not be used for this program.

Everybody said it was impossible, but Colonel Thorndike said that at Halloran General Hospital it was being done. So I went up to see and found out they were doing it and doing a very good job. They had found ways to study what the ward master's duties were, how they could shift a few things, and do things a little better, just as Kaiser found how to build a ship faster. They released the ward masters an hour and a half a day. One hour they trained on how to do the job and the other half hour they were giving the program. They were filled with enthusiasm. I think we are going to have to utilize what manpower we have. The present manpower setup doesn't give us enough manpower in the hospital unless we use ward masters. The question is not to say "It can't be done" but "How can it be done?"

This really hasn't very much to do with what I should say here. But there is one other thing that is in my notes, and that is, I think we should use the patients we have in our hospital. We have in the YMCA or college programs, student leaders. That is easy because we have those people for a year at least. When you are training patients, you don't have them for a year, we hope. Instead of that, we hope that you feel when you train a good patient that he should be out of there in a week. You want to put him out to help the Army.

So I think this training program which you men will have to face is a much harder job than we people in the schools have, but it is one of the most important things in connection with reconditioning.

Two things happen. First, when you train a patient, you have the same situation as when one makes a leader out of a bad boy. Years ago I used to be a YMCA physical director. Whenever I had a bad boy, I usually made a leader out of him, and he made a better leader because he had leadership and initiative -- he made a better leader than the namby-pamby kid. There are certain boys you don't know are even there. They aren't naughty, or disciplinary problems; they are not obstreperous. They keep their gym clothes clean. You never notice them. I don't like a soldier in this Army you don't notice. I like a soldier who is bad once in a while. He makes a better leader because he has something on the ball. That means more work for some of these NCO's to help sell things to patients. They will do it because they believe in it and then the patients help to carry the crowd with them. I think leadership training of patients -- officers and enlisted men -- is one of the most important things we had to do.

I would like to take about two minutes to speak about the physical training program for the blind, because I think you will be interested. We are planning not to prepare a man to be a blind man in a blind school or institution but to prepare him to live in Clinton, Cedar Rapids or West Liberty as a citizen in that community. He must keep himself in good shape. If he is in poor condition, with a poor posture, he has two strikes against him already. What we need is a man with good color, good shape and good development. What can he do at home? There are a lot of things he can do at home besides calisthenics, and we can teach him those things. I have been experimenting around the YMCA, punching a bag with my eyes shut. One can also punch the heavy bag without use of the eyes, keeping in touch with one hand. He can do weight lifting and a lot more things more interesting than setting-up exercises. What can he do in the local athletic group or local YMCA? The blind wrestle beautifully. They have wrestling matches -- the blind schools against the sighted schools, and the blind schools often mop up on the sighted schools. The only handicap, the only consideration, that they ask is that the opponent snap his fingers or slap his leg until they make contact. Then the blind ask no special favors. They can engage in many sports. They can swim in a pool. It would probably be best if a blind man wore a white cap so that some careless person will not dive on top of him. He usually swims along the edge of the pool.

Aside from that he is alright and can row, paddle, canoe, take hikes and play quite a number of games. Many bowl beautifully. I bowled with a boy in blind school who made seven strikes in twelve frames. If right handed, he must have the alley where the ball rack is on his left and he keeps track of his direction with his left hand on the ball rack. He has to be told what pins are up. He has to throw a straight ball, for he cannot see what his hook might do.

What we are trying to do is build a program where these men can go right ahead in local communities and do the kind of things they would do if they had eyes, if they have only one sighted companion with them. I thought that might be of interest to you so I just threw it in.

In summarizing, first, maintain what they have strength and muscular endurance: don't let the program be too light. But don't conduct foolish activities that they cannot and should not do. Get a program that is well planned, well diversified and one which is planned not only to give strength and endurance, but which also builds up special disabilities as is done in the rotating gymnasium programs. What they want is strength, strenuous fun and morale. Be sure to push the men through as rapidly as is consistent with their best interest. Don't set a four week program for Class I and II patients and expect them always to complete it in just four weeks. Some will take six while some will take only one week.

I have a few slides which illustrate certain aspects of this program. I will run them through very rapidly to give you a version in pictures which will supplement the demonstration we saw yesterday.

COL. THORNDIKE: Thank you, Dr. McCloy. Dr. McCloy has stimulated me to expand perhaps a little further than he did on the normal physiology of physical fitness. I think it is well for us to review known physiological facts and the ways we can train individuals to be efficient organisms for the production of physical work. We have a muscular system; we have a cardio-vascular system; we have a central nervous system -- all involved in the picture, and all concerned with the efficiency of physical effort. If the organism did not operate efficiently, endurance would be completely lost. By physical training -- by whatever maneuver you are training for -- you teach and develop an efficient organism. We hear much of athlete's heart. Remember the cardiac muscle enlarges with physical effort. The heart muscle is hypertrophied directly in proportion to the total mass of skeletal muscle of the individual. If you have one of these large individuals, such as Charles, his heart size develops only in direct ratio with his muscular development. What is training, and what is over-training? Training, of course, consists of feeding a sufficient diet so that that sufficient product of digestion and, in this way oxygen and other things may be carried to the working muscles. Over-training is a fatigue mainly of the nervous system. It is not physical fatigue. It is mental fatigue. The individual gets stale, as we say. It signifies only one thing and that is that he has lost his keenness of mind and his reflexes, developed to be automatic by training. Things are going worse; he tries to do what he did a week ago and can't do it as well; he gets discouraged and the efficiency of his physical effort is lost.

We have some figures worked out on the metabolic rates of different types of physical work. These have been published and I will just repeat them. The lumberjack or the soldier does eight times the normal metabolic rate for a period of over eight hours. The marathon runner's metabolic rate will increase fifteen times the normal rate but he can maintain that only two or three hours. The hundred-yard sprinter has the highest known metabolic rate - during his run, it increases twenty times the normal rate but he can only maintain it for ten seconds.

So there is a direct difference between the training you give a soldier and the hundred-yard sprinter. The Army training program is aimed at endurance and a metabolic rate which can be maintained for eight hours or longer. One other thing that Dr. McCloy stated, which is very important, in running these obstacles races, is that the individual must use care and not be careless. Too many recurrent injuries are developed by the individual's losing his self-control and getting injured. Perhaps he thinks it is fun to take a sidestep here but that must be done in a disciplined and directed manner. Now we will go on to open the discussion. Colonel Rusk, have you anything you would like to say concerning Dr. McCloy's subject? If so, will you please come up here so we can all hear you?

COLONEL RUSK: I prinicpally would like to express my appreciation for the masterly approach to this whole thing. I would like to thank him, not only for his talk, but for the help the manual in preparation is going to be to this whole program and would like to hear some discussion about the reconditioning or the fitting for life of the severely disabled -- that 10 or 15% who are going to be our great problem. Primarily, the back injury, the amputee and the brain injury, with paralysis. What can we do for these men while they are still in the military service and before they are discharged from hospitalization? I would like to stress the fact that we have a great deal we can offer these severely injured individuals. First, they should not be made to feel that they are hopeless, bed-ridden invalids. They should be taught that there are many things they can do, with close cooperation with our orthopedists and with walking irons made for them. They can be taught the swinging gate on crutches and by stressing the reconditioning of the uninjured parts by keeping them from gaining too much weight while in bed, by keepingshoulder and arm muscles in top condition, you get them on their feet and started much more quickly than if that particular phase is neglected. I think that is also true of the amputees and will help them in their learning to walk and balance much more quickly. I should like to cite one case which illustrates very definitely this point.

There was a flight officer who crashed in a B-26 last July. He fractured his arm, leg, collarbone, and 12th dorsal vertabrae and was completely paralyzed from the waist down. He lost control of his bladder and a suprapubic tube had to be used.

He was three months in bed and that was before the days of any reconditioning program and because nothing had been done to recondition him and because no one had talked to him about the possibilities, he felt he was a bed-ridden invalid for the rest of his life. He was started on a program of upper arm and chest exercise for a period of six weeks. When his braces were fitted, he got on his feet and learned the swinging gate and in twenty days was able to take fifteen steps by himself. At the end of six weeks he could get around pretty well by himself and he could go back and forth to the lavatory without help. In regaining the upright position, and giving him some automatic bladder control, the suprapubic tube could be removed. This man who had looked forward to a life of complete invalidism was discharged not to a hospital facility, but to his own home and I had a personal letter from him saying that he had a chicken farm before he came into the Army. His wife said they had 2500 chickens now and he felt that within a short time they would have 5000 and nobody had to worry about him anymore. He could live with his disability and not be a burden to anyone. I think we should pay particular attention to this 10 - 15% group because there is a great deal which can be done for them by us.

COL. THORNDIKE: Thank you, Colonel. That problem is very much in our minds and, in my opening remarks, I referred to the reconditioning of the CDD cases. This is an example of what can be done with an apparently hopeless case. Is there any one from Camp Crowder who would care to discuss Dr. McCloy's paper?

LT. COL. JENSEN: I'm Colonel Jensen from Camp Crowder. Just a few things I thought I might say about Dr. McCloy's remarks. Dr. McCloy visited us several months ago and at that time gave us an idea of what could be done physically for Class III and IV patients. The Class III program has worked better with us than the Class IV program due to the interruption that Circular 26 caused in our ward master staff as those men were general service and we have lost most of those we had trained. Now we must train another group. I have before me a statistical analysis of the participation by Class III patients using the mobile gymnasium equipment in their wards.

Ward D-4 is a NP ward. The first week only fifty-five participated or in six days that would be approximately ten each day who felt able to take part in the exercise. However, during the eleventh week, one hundred thirteen took part. These wards run about twenty to twenty-five patients. Thus, by the end of thirteen weeks we had gained approximately 100% cooperation, all on a voluntary basis. In the surgical recovery wards, the patients stay no longer than seven days as they come to these wards from the operating rooms. As soon as they are well enough not to need special nursing care, they are transferred. In these wards only forty-two participants were gained the first week, but by the end of thirteen weeks, about 100% participation was also gained here.

This was not made compulsory. We feel it is a problem of getting voluntary cooperation. This program is now carried out in all the major wards in the hospital and the same increase in activity has occurred in each ward, primarily because there is usually one or two courageous souls who will try with you, and if you go back the next day there are usually two or three more, and finally, most of the men feel that they are well enough to participate. Over the obstacle course, pictured by the slides that Dr. McCloy showed, we have run over ten-thousand men. We have had one accident and that was due to carelessness. You have to make a little division on the obstacle course on what things you are going to have some of your men do. You certainly aren't anxious to have a man that has had an injury to his hand crawling hand over hand on a long bar until he is quite well. He may very well become a casualty. On the knee runs. Internal dearrangements of the knee you will try to keep off the inverted runs until about the end of the fourth week -- get the muscles of the thigh well developed with other exercises so that they can support their knee before they start on this strenuous program. Dr. McCloy pointed out in his visit to Camp Crowder that the program of bed exercises prevented atrophy of musculature. He told the story about himself of how he was able to get out of bed and return to almost normal activity, and following that through gradually, we have learned that you can remove the cartilage of a knee andby the time the stitches are removed, the man will walk without a limp if muscular atrophy is prevented during the time of early recovery. The knee cases are usually up walking around the ward with crutches but bearing some weight, the weight of the extremity on the affected side, three days after operation.

There is one thing I would like to ask -- I hope someone here can answer -- under Circular 73, it is pointed out that men who are trained as physical educational non-commissioned officers will not be lost on overseas assignment even though they are on general service. Now would that apply to ward masters who have been trained to carry out these programs in the ward?

BRIG. GEN. HILLMAN: Do you want an answer to that now?

LT. COL. JENSEN: Yes, I would like to have an answer.

BRIG. GEN. HILLMAN: I am inclined to think there is no privilege extended to all of those men. I think this only applies to the physical education instructors that are designated in this Directive 73.

LT. COL. JENSEN: I think this might be quite a problem for many of us because we are right at this stage now, for example, at Camp Crowder. Out of about 750 men 600 are general service men. They once were limited service but under Circular 293, they are qualified for overseas movement with a unit so we have a problem program of retraining our entire personnel, and that makes the Group IV program very difficult. Do you have anything to add, Captain Mueller?

CAPTAIN VERNETTE A. MUELLER, JR.: No, sir.

LT. COL. JENSEN: I want to say that Dr. McCloy, if he comes to your institution and works out in your gymnasium with the men and with your physical training people, will teach you in a half a day the things he is talking about really can be done. One other thing he pointed out to us is that the best utilization of the gymnasium was to have a standard progressive routine through the gymnasium. The men going from one piece of equipment to the next, and he also pointed out that they would use the equipment much better if they had diagrams as to how to use the equipment. He was correct. The gymnasium has been much better utilized since that time. I would encourage everybody to do this. Make the diagrams large enough and simple enough that the average soldier can immediately catch on to what different things he can do with dumbbells, for example, and the overhead bars. Thank you.

COL. THORNDIKE: We would like to hear from Camp Grant. Is Major Smith here?

MAJ. HARRY A. SMITH: General Hillman, Colonel Thorndike, and Guest Officers, this is my second encounter with Dr. McCloy. The first one consisted of five minutes at Camp Grant when he came up to study special training units, and I met him and as he left Colonel McEnamy said, "Wish you had been here to meet Dr. McCloy a little more because you are going to train some men for him." I said, "What are we going to do?" He said, "Darned if I know. Dr. McCloy is going to write you a letter and that is what you are going to work on." About four days later I got a letter from Dr. McCloy, and if I hadn't had that letter, I still wouldn't know what I was to do. That is what we based our training on the physical educators that you people now have. We got these men that were selected by Dr. McCloy and Major Barton and they were to stay with us just a few days before going out and we thought, "Well, we better give them something that will help these men before they go," and in the meantime Circular Letter 168 came out and that clarified it a good bit for us so we developed what Major Barton laughingly refers to as "command presents" to me. Every time he sees me, he says, "Hello, have you got command presents?" I don't have it but I know what "command presents" is and we continually harp on "command presents." Corporal Amic of this group who put on a demonstration for you yesterday was one of the choice people we had. I would like to tell you how we get these men. So far Colonel Peck up at Camp Grant is the Classification Officer, and every time a man comes in that looks good on paper he hauls him right in. If they have a physical background, he sends them down to me and we tell them right off the bat that this is going to be tough.

They are going to go out and work on a program where people up to this time have not been too interested in developing this program, and the question has been brought up since I have been here, "Are these men going to be given ratings?" Now that is all clarified. Last week I had six letters from different men asking, "Are you going to ship us? We have been reclassified as physically able to go overseas." We called Major Barton and that was straightened out. Yesterday morning I talked to Dr. McCloy and got some excellent ideas for developing this program much more than we have now. We are going to have to expand and include many more things than we have in the past. My experience in this has been limited, but fortunately I was sent around to visit a few hospitals, not to view what they had in the physical education program but to visit their personnel set-up. While there I found out that there were a lot of things we could teach these men to do that aren't in this program. We could teach them how to run the moving picture projector and how to conduct a training schedule so that each man we send out is able to sit right down and plan Class I, II and III programs. I will admit we have been weak on Class IV. I do not think we have had a good program, and we have not given our men adequate training for bed-bound patients. However, I do think with this new manual that Dr. McCloy is putting out we will be able to strengthen that, and I believe Camp Grant can give a high type of instructor. Some of you have used the men who have been trained. We have sent out letters asking how they worked out. We asked for your criticism and suggestions, and I think we have had just enough background now so that we are about ready to go ahead and do our part in this program.

LT. Col. Jensen: May I ask your a question, Major Smith?

MAJOR SMITH: Yes, sir.

LT. COL. JENSEN: By what machinery can we get men now at our stations to Camp Grant for training?

MAJOR SMITH: That is a good idea. I have a number of my men - excellent men - who would otherwise have been shipped into this program. I think Major Barton is better qualified to answer that than I. I hope he will correct me. If you have somebody who was especially qualified - in the past I have referred these men to Major Barton, who in turn has sent these men to me through The Adjutant General in Washington, but at present - but maybe I am infringing on someone else's talk to be given this afternoon. I believe they will explain to you how those men can be procured. There is a personnel survey set-up; it is preliminary and not complete. However, I believe that steps will be taken so these men can be sent to us. Is that right, Major Barton?

MAJOR BARTON: Yes, sir. To answer Colonel Jensen's question, he should direct a request that his men be sent to Camp Grant through channels. If that is approved by headquarters, we will secure The Adjutant General's confirmation.

LT. COL. JENSEN: Thank you, sir.

COL. THORNDIKE: Are there any further questions?

COL. WINN: In regard to these men who are being trained at Camp Grant, I would like to know whether a special effort is being made to orient them on the entire program, or whether there is emphasis placed upon the physical training they are given. I believe they should be used in the entire program so they can assist the educational officer.

I think they should not be sent out unless they demonstrate some enthusiasm for this work. I don't think they should be selected because they may have been prize-fighters and lack the intellectual and leadership qualities required for this type of work. I think they should be thoroughly familiar with the scope of the program, and I am interested to know whether these points are broughtout. They should also be interested to know whether these points are brought out. They should also be instructed in certain phases, at least, of hospital admininstration, and just what a hospital is like. They are not medical troops and have not had medical training. They will function better if they will come to the hospital with some idea as to what the whole thing is all about as far as the conduct of the hospital is concerned. So much for that.

Dr. McCloy has been with us several days prior to the opening of this conference and we have profited accordingly. I want to say that I am sure his talk here was stimulating to all of us.

COL. THORNDIKE: Any questions?

MAJOR BOYNTON: I would like to ask Dr. McCloy about bed exercises for specific types of surgery. In other words, when do you start exercises after an appendectomy or a hernia and when do you start after a Nicola? It would certainly be of interest to me and, if you have the time, it certainly would be appreciated.

COL. THORNDIKE: I am going to turn this over to Dr. McCloy. I can see I am getting into hot water.

DR. McCLOY: I will take this first question last. The manual has not been completed with regard to post-operative procedures, because of the fact that we are clearing that very carefully with the surgical staff of The Surgeon General's Office. We have been preparing specific kinds of programs for these various kinds of disabilities, though in general the bed exercise program will put most of the people through about the same program, but with some prohibitions. In these bed exercises, when we come to a knee exercise, the men with knee disabilities will not do this exercise; the man with an affected shoulder will not do the shoulder exercise; the one with an abdominal operation - when they come to the part that uses the abdominal muscles - will be told not to engage in that particular exercise. Just exactly when they will start on each one will be decided on two bases: First, insofar as specific recommendation in this manual is concerned, they will be made by the Orthopedic Surgeon, either Colonel Peterson or a surgeon appointed by him. That is something for which I certainly would not take the responsibility. The decision as to when any patient may start an exercise is a function of the ward surgeon. The Orthopedic Surgeon will decide when a patient with a Nicola may start. It will take a little time to educate all the physicians in our hospitals to be willing to try many of these things. That is no criticism of organized medicine. Nobody paid you when you were a civilian doctor to keep him in apple pie shape; you were paid to get him out of danger, and then he quit paying. You never had a clock hour of training on this in medical school. It goes back to your common sense, your cautious experimenting, and what you can learn from other people who are experimenting. I can't see any other solution as to when a man can start with a Nicola except the judgment of the surgeon in charge of that case; but I hope that in this manual there will be certain general statements put out by the surgeons in our office. If not I certainly would not be willing to state when any one case would start, except that I would say, unless he has an infection or something of this kind, he can start immediately, as soon as he has been afebrile for twenty-four hours with exercises of the other parts of the body.

Colonel Winn commented on the experiment of mine. I very carefully avoided any exercise of the abdominal muscles for two weeks. You can tell when you start exercising an injured part because it hurts when the muscles are being used. I knew what not to try. At the end of two weeks with the permission of the surgeon, I started first lifting my head and looking at my feet. I lifted my right shoulder and left foot until I had a little tension on the muscles. I had it on both sides, so I worked both ways. That was gradually increased so that at the end of three weeks I was doing relatively gentle exercises but trying not to contract the scar. I just put tension on it and kept my chest high. By keeping the chest high and the abdomen sucked up, no intra-abdominal pressure was exerted. With caution, anything, I am sure, that any surgeon with common sense would forbid any attempt to engage in dangerous activity.

I have omitted two or three things I would like to say here. I had an hour in which to give my speech this morning, but ran over to an hour and five minutes, and had to omit a few things.

I want to mention that when I first came into this program on the 20th of December, there was little or no literature. I skimmed the hospitals and I am very greatly indebted to many organizations. I am particularly indebted to Colonel Rusk and the Air Force group. They have been at this for a longer time. Colonel Rusk gave me letters of introduction to a number of Air Force units. I learned a great deal and I had no hesitancy in swiping anything that looked good. We are all fighting in common and are all working for the American soldier, and the Air Forces have been most generous with their cooperation and we hope to be as generous in return where we have anything to offer. The A, B, C classification of Class III and IV, dropping out seriatim came from Mitchell Field. The other hospitals where I went told me many things. There were places where they already had good programs. Almost all of them had something good and many of them had many things that were very good. While everything is not acknowledged in Army manuals, I want to express indebtedness to many of these people right now. This cart idea came from Camp Crowder. I saw excellent work therapy under Major Preston at Nichols who has done excellently what I have been talking about.

I want to say a couple of other things. There is a kind of surgery that has not received very much emphasis in general surgical work. If you have been a doctor in charge of athletic teams, you have had a different problem than if you were a surgeon in general practice. In general practice, if a man had a badly sprained ankle, you could keep him off it for a while. A surgeon in charge of a football team wants to get his man back on the team just as soon as it is compatible with the welfare of the man. There are a number of things that one can learn through experience of that sort. Colonel Thorndike has had probably more experience along that line than any other man in America. He has written an excellent book on it. There is another one by Lloyd, Deaver and Eastwood. Colonel Thorndike has procedures in his book which, if they are studied carefully, will give methods of treatment of "athletic injuries" that should be of help in getting many soldiers out of bed and into circulation much sooner. They have done just that in Colonel Thorndike's set-up at Harvard which, I think, is far the best of any place in the world. It is an extraordinary medical set-up. They take care of the most insignificant injury on the intra-mural team as well as they care for the star athlete.

On this prospective CDD, Colonel Rusk brought out something very important. Because of the lack of time, I didn't touch on that.

That is one of the things General Kirk and General Hillman are very much concerned about and it takes more manpower than the hospitals have available now. That is one thing the hospitals will have to take into account and a program is being worked out. At the present time we are hitting the program hardest that will get the most men back into active duty as soon as possible. At the present time, the others are getting all we can give them.

On the matter of these diagrams that Colonel Jenson brought up, let me illustrate. Let us take things like bag-punching. I went around the hospitals and saw two things done ordinarily -- they always have a boxer or two. They do straight-away punching and things like that (he illustrates) which are very hard to do -- you can't master it in three or four weeks. Now these things where you use elbows, where you get an excellent shoulder and arm movement, here, (illustrating) side-bending makes it much more effective. This wasn't being used in any place because most people didn't know about it. When those diagrams were put up by the platform, the men see what they are; nobody has to say, "Do this" or "Do that", they say, "Go on to Number 3 or 4". You can work your way through this with a much more extensive curriculum and it can be done with a much more economical use of manpower. You know what that means. I think that some graphic aide can be prepared with CDD patients and many of the others. I would also like to see more experimenting done with resistance exercises in bed.

In connection with another project, I investigated Charles Atlas. He was very cooperative. Many of the types of things he puts out seem to interest literally hundreds of thousands of American men. Shoving one way or another, one can goldbrick beautifully on it. We will have to motivate them to do it. Atlas gives you a little handbook and makes you feel you can blow your muscles up with a little manpower of your own. We can't go around and blow up their muscles, we don't have enough manpower for that. How can we inspire some of these fellows to <u>want</u> to do some of these things in bed?

One of the officers with me was talking with a Class III patient who is a boxer. He had a bad lower leg in a cast. He was excellently developed. We were looking at him and wondering how he got that way. He got that way by working on himself -- of course, he had something to start with, but he has also inspired a whole flock of other fellows around his bed to do the same. You can't put all your Charles Atlases in hospitals just to inspire other boys. How can we inspire people to do more than the minimum to keep in shape? That is a psychological problem. Colonel Winn emphasized that very well. It is a part of morale. The man who gets in there with a good physical attitude and stimulates himself to want to be a better soldier stimulates morale. The man doing the educational job can stimulate him. I can think of some of these young Red Cross ladies who would make him want to put three inches on his chest! I don't see why we shouldn't use every means possible to accomplish this.

COLONEL THORNDIKE: I think we are very much indebted to Dr. McCloy for his contribution to this program.

Colonel Winn, I think your suggestion concerning widening and expanding the program at Camp Grant will be undertaken right away, so those instructors will not only be qualified in physical reconditioning but also will know the whole program and how it is coordinated.

In answer to Major Boynton's question on starting hernia convalescents on reconditioning, we have a directive which limits the speed with which we can return hernias to duty. This is the only directive which limits the program, so far as I know.

24-80145-600

However, it is not the reconditioning officer's decision as to when to start; it is the decision of the professional service; it is the medical or surgical chief who will release the patient. That decision belongs to the professional service.

GENERAL HILLMAN: May I say a word?

COLONEL THORNDIKE: Yes, General Hillman.

GENERAL HILLMAN: It has been our experience in the War Department and the Surgeon General's Office that if we get out a directive or start a policy on certain professional matters, it is very difficult to prevent the pendulum from swinging too far. While we know that, in the past, we have coddled our patients too much or permitted them to remain inactive too long, I would dislike very much to have the opinion become widespread that we should not be conservative in the time for them to remain in bed and, swinging over too far, find that people are being taken out of bed and exercised earlier than sound surgical and medical judgment dictates.

Another point concerns the CDD cases. We feel just as much obligation to the man who is going to leave the service as to the man who is going to be retained for military duty. Don't let anybody get the idea we are less interested in that group. The approach to that group, however, will be somewhat different. The emphasis on military subjects can give way to emphasis on restoration to useful work in civil life. In our amputation centers, special problems present themselves and we have not gone into a wide discussion of them here. The orthopedic surgeon who handles the amputee knows that a special effort and a special technique must be applied to teach him to use his one or in some cases, two artificial legs, or his hand with a hook. These are special problems and we have omitted any detailed discussion of them here because the time would not permit. Furthermore, they are not problems which one generally meets in hospitals. The same thing applies to our management of individuals with defective hearing and blindness. They require special approaches to their reconditioning problems. It is not to be thought that because those matters have not been discussed here, there is any lack of interest or lack of planning for the proper handling of such cases.

COLONEL THORNDIKE: Thank you, General Hillman. We will now proceed with the Educational Reconditioning Branch, and I am going to turn this part of the meeting over to Major Briscoe, who will carry on for the rest of the morning. Or would you rather have a rest now?

(RECESS)

COLONEL THORNDIKE: Will the meeting please come to order.

MAJOR WILLIAM S. BRISCOE

The rest of the meeting this morning is going to be divided up between a number of people whose names I would like to mention now, and who will, in turn, re-introduce each other. We have with us Major West and Lieutenant Humphrey from the Morale Services Division, Major Benbow, Captain Evans, and Major Bishop from the special school for Morale Services, Colonel Ramsey and Lieutenant Kohn from the Special Services Division. We are going to cover four topics this morning.

We should first like to ask the question, what is the place and primary function of education in the reconditioning program? Second, what specific objectives does the education program hope to achieve for convalescent Class IV, III, II and I patients. Third, in planning our attack on the problems of reconditioning patients, what are some of the essential things to keep in mind concerning personnel, program and methods. Fourth, in calling your attention to the tools with which you may do this job successfully.

I should like to cite an example from World War No. I, medical history reports a soldier who was wounded in his left arm and leg. His leg was amputated and his arm was long immobilized by a draining wound. While his wounds were healing he lay abed for a long time on his back. The nurse seeking to relieve tension on the flexor tendons of his right leg placed a pillow under his knee. The soldier lay in this position for several months, so that by the time his wounds were healed his right leg was crippled because of muscle atrophy from disuse and from having his leg in a bent position, for so long a time. The medical reporter of that day in describing the cases explains how many months of physiotherapy brought function back to his right leg again, while casually mentioning that the man's right arm, which he used to wait on himself, was all right, and missing the point that had the soldier's right leg been exercised as his right arm was it, too, would have been all right.

If the man's mind was as unexercised during these months as his body was, it is entirely conceivable that great mental harm was also done him.

Today things are different. As soon as a man recovers from shock and is on his way to recovery, general exercises are begun to keep the body in condition and at the same time mental diversion, recreation and education are given the patient to keep his mind healthy and well. Not only does exercise of body and mind prevent the debilitating effects of disuse which can amount to positive and lasting injury, it also promotes healing and speeds general recovery.

The Body is Reconditioned Through Exercise

When the soldier is able to move without pain or injury to himself, trained physical education experts come to the ward and give to each man the exercises which are especially designed to keep his general physical condition as near normal as possible. The muscle tone which is maintained improves his whole body, the injured as well as the uninjured parts. His heart muscle is strengthened and general circulation improved. His lungs and other organs are kept in better tone. Hence the body is a better functioning unit and so its powers of recovery are heightened and illness shortened and healing hastened.

Such exercises are not merely calisthenics but may be, in fact often are, in the nature of interesting games which also divert the mind from thoughts of self and sickness and injury, and thus serves a double purpose, being mental therapy as well as physical.

The Mind is Also a Part of the Body and is Reconditioned by Exercise

It has been mentioned that when one's body has been injured or severely ill his mind also has suffered shock. Particularly is this true in war, where often there are added strains of battle and the ordinary anxieties of war all soldiers suffer in some degree. So in the beginning of convalescence it is advisable for a while at least to forget about the war and to put one's mind on things which for him represent peace and security.

This differs for different people. Even the nature of the illness may be a difference in this respect.

In the beginning of convalescence, therefore, the patient may be given things to think about which divert the mind from anxieties or from thinking about himself, or his illness or injury, to things outside himself. This may be recreation, entertainment, or it may be some form of education, for if a man has intellectual interests an appeal to these is generally to appeal to areas of thought which represent security. As a patient recovers physically and grows stronger more sustained intellectual effort is encouraged and finally specific and increasingly intensive reorientation to the job of being a soldier is begun, first through studying the progress of the war, later through specific military study or training. While this may be the general pattern, for some men the best thing may be to place a weapon in their hands as soon as they recover from shock, which they can assemble and study - even play with. A gun is a mechanism which is interesting to most men. Many interesting activities can be carried on with a rifle or machine gun, such as dismounting it blindfolded and reassembling it, for example. Seeing who can do it best is often a fascinating diversion.

For others to talk out their anxieties through discussions or classes may be the thing necessary. Whatever mental activity is best should be provided as directed by the physician in charge.

To serve these mental needs adequately the educational program must be a broad one applied with intelligence and shaped to the requirements of individual patients. Library reading, selected radio programs, movies, discussion classes, correspondence courses, dramatics, music, art, opportunity for shop experience, are typical of the broad program which must be offered. It is obvious that so conceived the program will involve the joint planning and cooperation of the Education Officer, occupational therapist, Red Cross worker and physician.

Reconditioning is not merely physical - it is also mental. Educational Reconditioning aims primarily at preparing men to go back to the most active duty possible for them. Reorientation is therefore the keynote.

THE MISSION

During early convalescence the aim is

a. To divert the patient from thinking of his illness or from thoughts related to shock, fear, and anxieties of battle by offering educational and recreational experiences calculated to promote feelings of security.

b. To explore the possible educational interests and needs of men and to explain to them individually these various educational opportunities.

c. To incite a spirit of inquiry concerning subjects in which men are interested.

d. To reintroduce gradually interest in the progress of the war, problems on the home front and general interest in every day happenings.

During the ambulatory convalescent period while patients are still on the ward the aim is:

a. To reintroduce the idea of duty by requiring that some time daily be spent in study and reading or other educational pursuits appropriate to the needs and abilities of the individual.

b. To stimulate serious educational activity by offering short unit courses, lectures, movies, promoting discussions, correspondence courses, etc.

c. To promote solidarity of purpose and spirit through enlisting patient participation in the program in preparing assemblies, assisting with teaching, giving lectures, entertaining, etc.

d. For those who must retrain themselves for participation in a new field in or out of the Army, opportunity should be offered them to explore their possibilities and they should be helped to assess their qualifications and their interests and should be aided in planning the steps they should take to secure help available to them in re-planning their lives.

During the convalescent training period in Sections 1 and 2 the aim should be:

a. To offer military subjects on duty time which will be of value for all men regardless of the status of their training.

b. To offer subjects so arranged as to parallel the physical training program, i.e., requiring increasing physical activity.

c. To continue in off duty time the educational and recreational opportunities offered on the wards.

a. PERSONNEL. The success of the program of educational reconditioning will depend in large measure on the wisdom shown in the selection of personnel to carry it on. Probably no one of us is really qualified to do the job adequately, - that the completely right man will be found for any job is too much to expect. However, there are a few important facts to keep in mind in selecting educational officers:

1. The Education or Orientation Officer's job is to incite other people to activity. In proportion as he can get the men themselves to carry on their own program of educational activities will be successful.

2. The Education or Orientation Officer is not a teacher in the school sense, but rather in the sense of being a leader of adults. He will seldom find it necessary to resort to orders to accomplish his aims.

It follows that three qualities among others are necessary for the officer who is to be a teacher of adults:

1. He must have an attractive personality. He must be liked by the men (Personality may be defined as the way the other fellow sees us).

2. He must be a mature person. Since the education and reorientation of wounded soldiers is more than an intellectual process it follows that the educational officer should have had some experience in living as a prerequisite for leadership.

3. He must be a man of character and of conviction in whom one feels the security of stability which is based on understanding of what the war is about and on even deeper personal orientation to things which count.

4. The Education Officer should possess a good general education and cultural background.

5. He should have been trained for his job by his previous experience in education, though this is very secondary to the qualifications named above and if lacking can be corrected by training which will be made available.

PROGRAM

You have in your hands a program for Groups 1 and 2 and one for groups 3 and 4. I shall not take time to go into detail regarding these except to point out a few principles which it seems to us in the Reconditioning Division should be observed.

GROUPS 1 and 2

1. For groups 1 and 2 education during duty hours should be military instruction.

2. Subjects for study in convalescent sections attached to general hospitals should be selected which can be justified on the basis of their value to all soldiers irrespective of branch of service or status of training.

   Question for training: We are not sure whether this should apply in the case of the station hospital or whether plans should be made to continue training. In the case of station hospitals it would seem highly advisable to contact the Post Plans and Training Officer for advice as to subjects to be taught and as to methods to be employed.

3. Mental hygiene, personal and sex hygiene, sanitation, first aid and similar subjects can be taught effectively in a medically supervised unit and should, therefore, be stressed. WD Circular 48.

GROUPS 3 and 4

The program for Groups 3 and 4 you also have in your hands. The major military emphasis in this program is orientation. The wide differences which exist between patients as respects military discipline, training, education and ability as well as the specific natures of their illnesses or injuries require that any program of reconditioning on wards of necessity consider the individual patient. The implications of this are that first, there should be a wide variety of activities available to patients, and, second, there should be selection of method as to teaching and application of the program.

In the field of physical reconditioning it is necessary to recondition men in terms of their physical abilities and disabilities. The same is true in mental reconditioning. The program for reconditioning on wards will consist of the following activities:

A. Physical training including calisthenics and games. Amount of time daily to be determined by the ward physician. This program to be carried on by the physical training sergeants at least twice daily for all those patients for whom the ward officers feel such program is appropriate. These activities will include bed exercises, exercises on the wards, and for those who are capable, outdoor exercises, especially designed games for wards, as well as exercises especially designed for individual patients.

B. Education will include the following:

   A. Supervised study - 1 hour daily.

1. USAFI Correspondence courses
2. Group discussions
   a. Self-teaching texts
   b. Special Editions of Standard Texts
   c. Special training materials.
3. Language records
4. Educational films
5. Subjects for which materials may be available through educational institutions, local schools, etc.
6. Directed library reading.

B. Orientation and Information - 1 hour daily
1. One unit lessons or lectures on subjects of interest to men.
2. News reviews and radio programs selected in advance for their educational content, through use of FREC radio service.
3. Discussion groups on topics of interest to men.
4. G. I. Movies and educational films.

C. Military Subjects - 1 hour daily
1. Lectures, demonstrations and discussions covering:
   a. Selected subjects taken from WD Circular No. 48, dated 4 February 1944
   b. Defense against mechanized, air and gas attack
   c. Mapping, and other subjects found to be pertinent and of interest to soldiers.
2. Training films
   a. Showing of new films
   b. Review and discussions of films already shown

D. Orientation and activities directed by Occupational Therapists and the Red Cross

E. Ward fatigue and duties.

METHOD: There are a few psychological principles which should be kept in mind in respect to reconditioning soldiers for duty or for return to civilian life.

1. In conditioning men no lapses from standards of desired response should be permitted. To illustrate what is meant one may cite the fact that military drill and military ceremony when employed in reconditioning should conform to correct and proper military standards. The tendency to excuse men from proper observance should be strictly avoided. If men cannot do what is expected of them it would be better to avoid the requirement than to condition them to an inferior standard, for to do so not only lowers standards of proficiency but breeds poor moral as well.

2. Interest is necessary to efficient performance in learning. This is especially to be borne in mind in respect to military education. For example, trainees who have been in combat will resent being forced to view again training films which they may have seen in their preliminary training. It is safe to say that any showing of training films to experienced soldiers should be for the purpose of reviewing or emphasizing a point which has arisen during a previous discussion of the topic being considered. Certainly the audience should be carefully prepared in advance for re-showings.

3. With adults interest is more easily sustained if problems are considered and if the individual has a part in planning and executing the solution.

In his studies of the normal mind, William Burnham, out of the wisdom of a long life of study of what makes humans behave as they do, stated a basic formula for mental health as being "a purpose, a plan, and freedom to carry it out". This formula works equally well in adult education. In Army language the philosophy is recognizable as being a clear cut mission, a plan of action, and the freedom and responsibility for its execution.

4. Reward, especially if it is intrinsic, that is to say inherent in the satisfaction that comes from the recognition of a job well done, is very effective in promoting educational activity. Several hospitals have found it effective in promoting cooperation of trainees to prepare a letter for inclusion in their 201 file evaluating the trainee's cooperation and success while in the convalescent program.

5. Adults as a rule are not so docile or curious as children are. They must see a practical value for them in what they are being taught; it must be related to their pattern of interests. Someone has remarked that for the most part "adult education is the job of teaching people to do better what they are going to do anyway".

6. The more heterogeneous the group is in respect to the matter presented, the simpler, more concrete and less symbolic should be the mode of presentation.

In considering education in relation to reconditioning let us raise these questions for thought:

1. What is the place and primary function of education in the reconditioning program?

2. What specific objectives does the education program hope to achieve for convalescent groups IV, III, II and I?

3. In planning our attack on the problems of reconditioning patients, what are some of the essential things to keep in mind as respects:

   a. Personnel
   b. Program
   c. Method

4. What auxiliary support may we expect in the way of materials and services from Morale Services, Training, Special Services and the Red Cross?

I should like to repeat again that the program will be successful only in proportion as you pick good men to run it, and if these men recognize that it is the responsibility of the patient himself to educate himself, and that nobody else can do it. Then, finally, we have found in school work, the type of tools you place in a man's hands are very important. The matter of teaching of reading has improved tremendously in the last twenty years chiefly because better textbooks have been placed on the market. If you put a hoe in a man's hands, he can't do much with it except hoe. The Morale Services Division, Training Division and Special Services Division are going to tell us about some of the things we can use in this program and how we can get them. The first speaker is Major Reed.

MAJOR ERNEST H. REED

I would like to take just a second to express my appreciation, even my amazement at the arrangements that have been made for this conference. It certainly bespeaks nothing but praise for the Surgeon General's Office and to Colonel Winn for the local arrangements. I, as an outsider, appreciate them and marvel at them very greatly. I thought I was an outsider, I should say, until last Friday when I suddenly discovered I was on the program. As such, I assure you, I have no intention of trying to give you a panacea for all military training problems. Even in the labyrinth, commonly referred to as the Pentagon Building, we who have recently been out in situations where we were actually doing the training have not forgotten what some of the problems are. We also realize that we can't accomplish everything there within those winding halls and that we can't solve everything or even a major portion of it by a lot of directives emanating from Washington. The big job is going to have to be done by you people doing the operating work, carrying out the training. Certainly those of us who have been out where you are know that very well. I have a sneaking suspicion, however, although I have no idea as to what General Porter has promised, that the ASF will be called upon to produce some of the things he has promised. I assure you, General Porter, we will do the very best we possibly can to see that those things get provided.

In the first place, something which has been touched upon already is the necessity of selling ourselves and selling the trainee upon this entire training program. I am personally conscious of the fact that in selling ourselves there are going to be a lot of difficulties arising, which will make it sometimes a pretty blue situation as far as facing the problems you are going to have to face. Also I am personally conscious of the fact that you are not going to have all the personnel to conduct this program you would like to have. They are going to be jerked away in a rotation policy, making it seem very discouraging. Despite that, I think we are going to have to keep in mind the manpower needs General Porter mentioned yesterday morning. By such a program as this we are going to make it possible for men to be available for full duty sooner because they will need less military training after leaving the hospital. They will be able to continue their work better because of this training they have had in the reconditioning program.

Most important of all we are going to avoid dissipating some very costly training. It costs a lot of money to produce a trained soldier. This intensive education dissipates very rapidly when not used in the hospital, even though the man may be reconditioned physically. Therefore, if, for any reason the military training side of his education is neglected for even a short period of time, it results in a great training loss. We need to avoid that as much as possible. Once we have sold ourselves, it is going to be much easier to go out and sell the man on the need for a military training program in this whole reconditioning program. All of us need refresher training, picking up new ideas that are presented from time to time. That is just natural. A man can be sold on the basis that it is going to be a shorter time before he is released from the hospital and goes back to his training unit. He is ready sooner to take his full place in the military program after he leaves the hospital. Also a very very strong inducement to the individual soldier can be placed on the fact that the things he learns while the reconditioning program is in process may be a source of advancement for him when he goes out into a unit. He knows things and he knows them better than he knew them when he came into the hospital. As such, he has possibilities for additional stripes, and can become a leader when he goes back into a unit. To me that is a very strong motivating force that can be used to sell many of these men on the program.

Perhaps some of them can learn about new subjects, new military training skills which they haven't had. I think even there you can utilize Class 3 and 4 people. Major Briscoe has mentioned keeping their minds diverted. Maybe I am a little prejudiced because I happen to be associated with the Military Training Division, but I think we can do a tremendous amount of that with military subjects. If a man can be sold on the idea, we can give him a great deal of the military training and keep his mind on work even though he is flat on his back in bed. Our major emphasis for those men who are going back to duty still must be on preparing men for duty and not preparing them for civilian life yet. That will have to come later. How soon training can be given? To what men? Your own experts can decide better than anybody else.

Make the training meaningful with just as much practical application as you possibly can. I am just a little bit afraid of the term "military education" because I am afraid it may be misunderstood by some of the people in the ground forces and even by some of our own people. The second reason is that I think it is perfectly impossible to split completely that training which we normally think of as academic and that which is practical. The marches that you give most certainly ought to include practical training in defense against air attack, field sanitation, perhaps defense against chemical attack, and other training subjects included in Mobilization Training Program 21-2. Make it fit into the situation and tie those things together wherever you can. The War Department and General Porter's office is quite interested in this question of map reading. War Department Training Circular No. 6 takes it up in considerable detail. When you go out on a march, practice those principles of map reading out there. You can't do it all in the classroom. It doesn't mean anything. Teach a man while on the march to observe the terrain -- perhaps make a rough sketch of it. If you don't have maps of the territory, you can use a rough sketch very nicely. It is going to be a great help as far as making that training meaningful to the man and making it amount to something.

Utilize everything you have. There has already been stress here about using convalescents. I would inject one word of warning; don't just turn them loose. It is going to take close supervision. It is going to be worthwhile to use them more in the program. Patients are going to accept them very well because it is going to come from somebody who has been there and has seen what happened, but we must be careful not to assume that just because a man knows something he can teach it to someone else. That isn't always true.

Go back and keep digging into Field Manuals 21-6 and 21-7 to see what is available in training aids. There are new ones just out, by the way. Continually, new training aids are appearing. This list of training films which has been given to you this morning is excellent, but don't start depending on it entirely because it has already been supplemented by a new film. I saw training films being used very nicely here yesterday. We're rather proud of those training films as far as the Army is concerned. They have done an excellent job, but they are not a lazy man's answer to military instruction. You are still going to have to prepare the way for them; still have to summarize and emphasize points that have been brought out. You shouldn't think of training films as things of entertainment. When we're using it in intensive military training, we aren't going to sit on the back of our necks and enjoy what goes on.

There is one thing I haven't seen here -- I don't know whether you have them or not, Colonel Winn -- and that is graphic portfolios, which I think should be very useful in this program. You are all familiar with them, I am sure.

They are a series of charts set on a stand and may be used very well in training small groups of men or an individual who is interested in a particular thing. They are more or less new. We are bringing out more all of the time. I think you will find them extremely useful for class 3 and 4 men as well as others. Those things can be and will be made available if you will ask for them, if you can use them, and I am sure you can.

We have a definite obligation to utilize our manpower as efficiently as possible. I think we can best do that if we keep this man trained as a soldier. Avoid dissipation of costly training. Most of it I think is going to be basic training. However, some specialized training may be given; if a man comes to you as a radio operator if you can provide him with a little practice set so that he can keep his hand in during the period of time in the hospital, that will be excellent. It is going to keep him interested in the program and he will make a definite contribution when he gets out of the hospital.

We in the Military Training Division certainly hope we may be of help, and I know General Weible would have liked very much to have been here. If any of you have any questions to ask while I am here, I assure you I would be very glad to hear them. We hope to work very closely with the Surgeon General in this program.

COLONEL THORNDIKE: Thank you very much, Major Reed. We have already received a great deal of help from the Training Division. We have exactly forty-five minutes and we have to get all the rest of the speeches in that forty-five minutes. So I will call on Major Benbow of the Morale Services.

MAJOR BENBOW: The Morale Services Division is responsible for the provision of materials and services which relate to the maintenance and improvement of morale. The Division is specifically charged with three functions which are of particular importance in the reconditioning program. One - the provision of non-military educational facilities. Two - procedures and materials for orientation and information of military personnel, and three - procedures for the selection, training, and assignment of officers for morale duties.

The materials and services developed for orientation, information, and education of Army personnel generally have been and will continue to be available to personnel in hospitals. ASF Circular No. 73 now makes it possible for these morale services to be utilized to a much greater extent than was heretofore possible.

General Osborn, Director of the Morale Services Division, is intensely interested in reconditioning and will continue to see that every possible aid is made available to the program. Since the original directive on reconditioning was issued more than a year ago, officers of the Morale Services Division have worked closely with officers of the Surgeon General and Air Surgeon. For many months now the quantity of materials supplied to hospitals has bulked large in our total supply program. We are looking forward to this demand being doubled and tripled.

In addition to the services from Washington, each Service Command Headquarters now has a Morale Services Division and it is expected that these divisions will work with Service Commands Reconditioning Divisions in the same fashion as their Washington counterparts.

Specific materials and services for use in reconditioning are provided by the three operating branches of the Morale Services Division -- Education, Orientation, and Information -- and by the School for Special Services.

The Education Branch or Education Program of the Morale Services Division provides six services or materials which may be used in the education part of reconditioning:

1. Correspondence courses in hundreds of high schools, technical schools, and college subjects, through the U.S. Armed Forces Institute. Complete information about these courses and other services of U.S. Armed Forces Institute is contained in an envelope of materials which will be distributed during the noon recess. You have already seen the display of materials at the rear of the room.

2. Self-teaching course. These differ from correspondence courses in that lesson service is not provided. Insofar as possible the teacher is "in the book" in the form of detailed instructions, step-by-step directions to the student, self-administering tests, problems and questions with answers. To obtain a certificate the Institute provides an end-of-course test, administered by an officer. Though these self-teaching courses were designed for oversea use they are admirably suited to use in hospitals.

3. Textbooks for class use. These are special Army editions of standard civilian textbooks. Each book is selected for Army use by expert civilian consultants. Thousands have been distributed to hospitals for use in classes.

4. Foreigh language materials deserve special mention. Completely self-teaching spoken language materials have been developed in more than thirty foreign languages on the elementary level. Using phonograph records and a text that spells out the foreign word or phrase as it sounds in English these language materials teach the student to speak common words and phrases in a few hours practice. Advanced materials that make it possible to obtain a good command of the spoken language are now available in French and Chinese, will soon be available in a dozen languages.

5. G.I. Movies. Most of you are familiar with this weekly movie feature. Containing 16 mm shorts on education, information, and orientation topics GI movies supplements and aids the orientation - education program. Complete information about GI movies and expert advice on the selection and use of films in the education program may be obtained by writing to the Audio-Visual Aids Dept., U.S. Armed Forces Institute. Your envelope of materials contains additional information.

6. School and College Credit Service. This service is especially valuable for men who are to be discharged to civil life. It provides, through the U.S. Armed Forces Institute, and official report of military educational achievement for transmission to civilian schools and colleges for evaluation in terms of academic credit. The report may also be sent to employers. The report includes service schools attended, service jobs performed, courses completed with USAFI, and results of special educational development tests. This school and college credit service has proven to be very popular in the test discharge centers described by Col. Lynch last evening.

Detailed information on all these education materials and services may be obtained from the U.S. Armed Forces Institute, Madison, Wisconsin. Special provision for hospitals is made in ASF Circular No. 74, dated 13 March 1944. Materials and Service of the Orientation and Information Branches of the USD will be described by Lt. David H. Humphrey. Lt. Humphrey has just completed a tour of the nine service commands as a member of an orientation team that organized a pilot orientation program in one camp in each service command. He will preface his description of materials and services with a general description and definition of orientation.

LT. DAVID H. HULPHREY: As the Major stated, I have just returned from a tour through the country to set up pilot orientation programs. We feel that we did accomplish our mission. However, in the field we found generally that the officers did not understand what we meant by orientation, and for that reason I would like to take a few brief moments to explain the orientation program before I go into the subject of materials. Before I do that though I would like to say that the orientation officer who I will mention throughout this report is also known as the Morale Services Officer, and he is also known as the Educational Reconditioning Officer. Those three names, then, fit the same man.

For the sake of clarity the Army Orientation Program is divided into six objectives.

The first objective — to know why we fight. Obviously behind this lies the motivation for the whole conduct of the war. If a soldier really understands why we fight our problem is greatly simplified. General Montgomery, in Africa, made the statement that he thought perhaps the morale was too high among his men, and the reason was that the men did not report for sick call. They did not take care of themselves. They did not want to get out of the line of duty. If a man understands well enough why he is fighting he will want to get back into the line of duty as soon as possible, and the Reconditioning Program will be greatly facilitated. To know why they are fighting, that is the whole thing, in fact that is the basic objective of the Orientation Program. To really understand what is the background of this war, and what we are now engaged in trying to do.

The second of our objectives is to know the enemy and by that we don't mean just his training, his equipment and the size of his forces. We mean to really understand that the enemy is waging an insidious psychological warfare aimed at us at this particular moment, and has been waging that warfare for a long time. We know that the enemy is dividing us, one ally from another and internally within our nation. We know that the American soldier is told in many seemingly innocent ways that perhaps we are fighting for the British Empire. We know the British soldier is told that they are fighting perhaps to have the British Empire annexed to Wall Street. We know that the Russian soldier is told that they are fighting for Capitalism because they are told that Stalin has betrayed the revolution. In other words propaganda is directed where and how it will do the most good. We know it is propaganda and we know it is based upon lies. We also know that internally we are being divided among ourselves. We know that in America the very nature of our country is such that we provide a fertile field for racial, religious, political, and economical antagonisms and we know that we are being torn asunder by deliberate planned methods. We must be aware of that and our soldiers must be aware of that. They must know that by using terms, such as, "Damn Nigger, damn Catholic, damn Jew, or damn anything else" they are playing Hitler's game and not ours. There are men being paid by Hitler and Tojo to do exactly that same thing, and when we do that without thinking we may just as well be paid from the same source. We know the propaganda warfare of the enemy takes other channels. For instance, we were told for a while of the invincibility of the German Wermacht. It didn't work to well with us as in some other countries. But we know there are some hang-overs from that even here because when such things as reports about secret weapons come out we find them thinking to themselves or saying "This is where the German strength really lies". Now they are coming out with secret weapons we must fear. We know that that is a propaganda technique. We know when that didn't work very well the Germans are trying the other attack. We are being told that the Nazi Party and the German army is at odds and they are going to be split up internally — it is not being used now, but it will be and has been used before. We are told all sorts of things about the breakdown in Germany. We know that again this is a propaganda method to make us complascent.

You men know what a terrible problem we have to overcome complacency. The fact that our troops are aware of it and understand it, at least, they cannot be as affected by it. We know also that another technique is the technique of a negotiated peace. The Germans say they can't lick us and we can't lick them so why fight? We also know that the War Department tells us our definite aim is Unconditional Surrender. A negotiated peace, peace now, as sometimes stated, means Fascism later. We know that if we give the German army time to correct their mistakes that all too narrowly lost them the war, maybe next time they won't make those mistakes. They are not asking for peace now because they are licked, but because they feel that is the way to accomplish their eventual mission - the domination of the world.

Another objective of the Orientation Program is to know our allies and by that we certainly do not mean to white-wash our allies. We mean to arrive at a workable understanding - to arrive at an understanding that our allies, whatever our differences, are fighting for the same thing we are fighting for - that is to wipe out Fascism. Our differences must be overlooked. We must put aside prejudices, we must not let the psychological warfare build up within us things which are not true.

Another objective is to establish pride in outfit. By that we mean not just a feeling that this is the best outfit but a real faith in the training and equipment that goes with that outfit. A job satisfaction, a realization that no matter what job a soldier has, even not to his liking, it is a necessary job and must be done, and that is how he should contribute to winning the war, and that is a good thing for him to do it. It gives him a sense of participation, not only in his unit, but in the entire war, if he feels that he is working with other men to achieve something purposeful.

The next objective is to know the news of the world and its significance. By that I mean, of course, what is behind the news, not only the mere fact that the news states that so many bombs have been dropped on Germany. What is the purpose of that, why are we spending the time and effort on that? If we are going to have the best informed soldier in the world, which is one of our aims, we must realize that the current events of today are the historical background for the events of tomorrow. There is no easy way to teach a man history, but if we teach him day by day, then when the time comes to make his decision he will have had the history. He himself will have known it.

The last of the six objectives of the Orientation Program is something which shouldn't even have to be stated. It is to have faith in the United States and in the future of this country. We know some people don't have that faith, and we know some people are telling our soldiers that they should come home and take over this or that; that they should come back as storm troopers, which is the thing we are fighting against. If a man has faith in the United States and its future, he will come home and participate in that future as a citizen and certainly not as a storm trooper. The very potentialities of our country have hardly been tapped. Our democracy has a long way to go, and if our soldiers realize that, they will have a greater understanding of what we are trying to achieve.

To accomplish the objectives the Orientation Program we set up a ten point program within each camp. That program has to be adapted to the unit and in case of the hospital, it again would have to have further adaptation, but the Orientation Program is a directive which is required of all military personnel, officers, enlisted men, hospitalized or otherwise - it is all military personnel.

The first of the ten points is the one-hour per week orientation discussion. That is, of course, the basic orientation program. It is a part of the regular training, and it is to be given during duty hours.

This hour belongs to the men. It is not by any manner of means a propoganda hour; it is a discussion directed along channels by as expert a leader as you can get from your own unit. It is to be directed along basic orientation material, along current events, but it is a discussion; it is a democratic method of bringing ideas out into the open, rather than letting them wrangle over it in his mind and cause him to arrive at warped and exaggerated ideas.

The second part of the ten-point program is a meeting between the orientation officer and the part-time men who are conducting orientation within the wards or within the units. The reason we suggest that meeting is because we know that the part-time men or enlisted men do not have time to conduct research and preparation that is necessary to put on a good orientation hour. The orientation officer has prepared that material. If he can meet with those men before their orientation hour, he can brief them and get across the information.

The third point is to establish one or more orientation centers. You have seen at the back of the room a partial orientation center set up, so you can see what we mean. Actually it is a center located where the men congregate in groups. It consists of source materials, books, pamphlets, pictures and posters which graphically illustrate the orientation program. An important thing which we do not have here is the news items. By news items we do not mean newspaper clippings; the men can read newspapers themselves. We mean to interpret, simplify, and clarify the news so the men can get the news without effort they have to do by reading the newspaper. We do not mean coloring the news. We do this so that the soldier can understand what the news means to him.

The fourth point of the ten-point program is the use of the news summaries. Most units have either a daily or weekly news summary. This summary is not an attempt to beat the newspapers at their game. It is merely a simple and clear resume of the news that the men can pick up quickly. This summary is sometimes given over a loud speaker system; sometimes it is mimeographed and distributed.

The fifth point is the use of the unit newspaper for orientation material, such as editorial, news analysis, cartoons, quizzes, etc.

The sixth point is the liason relationship between the orientation officer and the men concerned with morale. The orientation officer is a morale officer. The relationship between himself, the Medical men, the Red Cross workers, the Chaplain, the librarian and the provost marshal - all of these relationships will be of great aid to the orientation officer.

The seventh point is the morale report that the orientation officer prepares for the commanding officer. Of course this depends upon the Commanding Officer as to how often he wishes them and in what detail.

The eighth point is off-duty discussion groups, which is part of the educational program. Often in the regular orientation hour questions come up which the men would like to discuss further, and they would like to have time to have some of them presented. Very often groups start with four or five men. I know of cases where they have grown into the hundreds.

The ninth point is the use and presentation of dramatic skits, programs, etc. These are not to be used during orientation hours, but are to be used on off-duty time, or other curricula time. These methods can be a very effective method of getting over orientation subjects.

The tenth point is the orientation of officers themselves by the orientation officer. This does not necessarily need to be a formal meeting. It is the definite responsibility of the orientation officer.

As for the material sent out by the Morale Service Division to aid the orientation officer in conducting these programs. In addition to the educational materials previously mentioned, we have first films, the "Why We Fight" series which you have all seen. Another series "Know Our Allies" -- the first of which has been issued about Great Britain. The GI Movies have already been mentioned. News maps have been issued on the basis of one to every two hundred men. Those are not enough if they are being put in offices remote from the men. After they are no longer current, the officers can use them for whatever they want. Recordings have been sent out. They are orientation subjects -- for instance "The Nazis Speak". It is proposed they will send out other recordings as soon as it is determined how effective they are and in what way they can be used.

There are the orientation kits which have been posted on the walls in the back of the room. We put a copy of Kit #3 on your desk. These orientation kits have books, pamphlets, maps and what we call fact sheets. Fact sheets are what we write to get to the orientation officer and part-time men information they could not get easily from books or other references. We are also sending out a basic library to the orientation officer. It contains eighteen volumes selected by a civilian committee of experts on international relations. Additional volumes will be sent out from time to time in orientation kits.

We published a digest for the orientation officer. For instance, the March issue includes a photographic explanation and drawings on how to set up an orientation center such as we have set up here. Then there are the newspaper services which are not necessarily the concern of the orientation officers. There are such things as the "GI Galley" and "Clip Sheet". Those provide him -- for instance one case -- with maps which he can put in newspapers to bring the men up on the war. Certainly, not least, is the issue of "Yank" with which I think you are all familiar.

MAJOR BENBOW: Circular 73 provides an educational program by the Morale Service Training Division. To give you a description of the training facilities, Colonel Quarterman has sent Major Bishop.

MAJOR W. A. BISHOP

The school for Special Service is a Class IV installation operating under the control of the Director of Personnel, and the joint supervision of the Director of Training and the Directors of the Special Services and the Morale Services Divisions, Army Service Forces. It is located on the campus of Washington and Lee University in historic Lexington, Virginia, and is commanded by Colonel William H. Quarterman, Field Artillery.

The mission of the School for Special Service is to provide appropriate training for officer and enlisted personnel assigned to duty in the Army Athletic and Recreation Program, and the Army Orientation and Education Program. Two distinct courses -- each of twenty-eight days duration -- are provided for classes which average three hundred students each. Students are sent to the School by commanding officers from the three major elements of the Army in accordance with quotas allotted to service commands, air service commands, theaters of operation, and the Directors of the Special Services and Morale Services Divisions.

It is the experience of the Headquarters Divisions in Washington and the School itself that a more careful selection of these special

staff officers - the Athletic-Recreation Officer and the Orientation-Education Officer - is essential if not indispensable to the achievement of their important missions in the field. WD Circular 287 describes the duties and qualifications of the A&R officer while WD Circular 261 describes the duties and qualifications of the Orientation-Education Officer.

The ideal educational reconditioning officer is conceived as an individual with a consuming interest in presenting the justice of the cause for which we fight, and will be acquainted with the facts concerning the causes, issues and course of the war. He will be capable of organizing and administering a well rounded orientation and educational program and to advise and guide the convalescent in the solution of his educational problems. He will preferably be a college graduate and will possess the ability to present his views clearly and convincingly. Whenever practicable he will have been a company commander and, as is suggested by WD Circular 73, may be found in considerable numbers among the recovered casualties of the fields of battle.

The instructional program of the School for Special Service is designed to train selected military personnel so that they may effectively assist commanding officers in developing and maintaining the high levels of mental and physical stamina in troops for combat. It is therefore reasonable to suppose that this program, with minor revisions and necessary adaptations, might be appropriate for educational reconditioning personnel as well.

The Athletic-Recreation Course provides administrative and leadership training in athletic sports and games (based on TM 21-221); physical conditioning (based on TC 87); soldier theatricals; soldier music; and the procurement and use of the Special Service funds and facilities. The Orientation-Education Course offers leadership training in methods and procedures designed to create in every fighting man a feeling of individual responsibility for participation in the war; for keeping him well informed as to the cause of the war and news of the world; and to give him an opportunity to add to his effectiveness through off duty individual or group study. All of these elements, and others too, are included in the Reconditioning Program.

It is axiomatic that the resources of service schools are available to whomever proper authority assigns them. I know that Generals Porter, Dalton, Osborne, Byron and Weible, and Colonel Quarterman would consider it a privilege to have the School for Special Service contribute to the training of selected reconditioning personnel.

MAJOR BENBOW: Thank you, Major Bishop. Major Bishop will be available during the discussion period.

MAJOR BRISCOE: I am not sure if all of us realize that there are two divisions of the ASF represented here. We very often refer to the Special Services Division, but there is another - the Morale Service Division - which is in charge of Army educational orientation, music, art and libraries. I am going to ask Lieutenant Kohn, Morale Services Division, to tell you about that service.

LT HENRY KOHN

The Special Services Division is grateful indeed for the opportunity to participate in this splendid conference. The attitude of Special Services toward the convalescent program is briefly this. We agree with you that when GI Joe becomes a patient he deserves the utmost service that the Army can furnish him.

Consequently, if there is anything that the Special Services Division has to offer that you can use, let us know and we will make every effort to supply it in the quantity and quality desired. We would like, in other words, for you to tell us what you want us to do.

To aid you in this determination, I am going to sketch briefly our present activities so that you can decide whether or not we can make any additional contribution to your program. As you may know, our job as a staff division is to assist commanders in building morale through athletics, physical training, live entertainment, music, movies, manual arts, libraries, and Army Exchanges. We assist commanders in these various fields by offering them specialists who are skilled, for example, in music, theatrical, arts or physical training. In addition, we publish materials to provide ideas and programs, and we make available certain equipment and supplies.

To be more specific, let us consider each one of these morale building activities separately to observe to what extent they may fit into your program. In one of the most significant phases of the convalescent program--physical fitness -- we can perhaps lend a hand. As you know, one of the functions of the School for Special Service is to train officers and enlisted men for leadership in sports and physical training. In fact many MAC officers have attended the course; but to date, the course has been designed and oriented for training healthy troops. We stand ready, however, if you so desire, to change the faculty and the curriculum so that men who are earmarked for hospital work receive the most advanced knowledge on graded exercise and physical training for orthopedics or other disabilities. Because of the proximity of the school to Woodrow Wilson General Hospital, students might participate in the reconditioning program there as a part of their training. Moreover, if we can aid you in the purchasing of athletic or recreational equipment, we would be glad to let our procurement specialists in this field assist you in any way practicable.

Turning to the field of live entertainment, most of the hospitals already receive camp shows, which operate under the direction of our division. At present, entertainment is being provided on a monthly basis through regularly established circuits. In addition, about May 1st or before, a special hospital circuit -- initially for general hospitals -- will increase the entertainment in those installations to once every two weeks. This is in accordance with the great majority of preferences as to frequency expressed by commanding officers. The entertainment on this hospital circuit will be carefully reviewed as to quality and style and a particular effort will be made to include entertainment having a beneficial effect upon the patients.

Among healthy troops, Special Services has sponsored and fostered self-entertainment, through soldier shows. We have sent scores of theatrical advisors to the field armies to stimulate and direct self-entertainment among the troops. The number of such soldier shows presented in this country alone literally runs into the thousands every year. If you have a place for them in your program, you can have officers and enlisted men who are specialists in soldier entertainment. In addition, subject to approval, the Special Services Division will prepare a monthly folio of entertainment material similar to the one we send overseas, comprising little skits, sketches, games, quiz shows and other material carefully selected and reviewed as to its practicability and utility for soldier shows in hospitals.

In the music field, Special Services Division again can furnish officers and enlisted men who are specialists. These men acting under medical supervision could make music an integral part of the reconditioning program. Whether the music is made available to patients by phonographs, public address systems, radio or by organized teaching of the playing of small pocket instruments and fretted string instruments which provide

muscular exercise - whatever the method - trained technicians are available to lead the program. Again, any personnel sent to hospitals for this type of work could be given special training at our school to acquaint them in the particular needs of the hospital situation.

Before leaving the music field, it might also be mentioned that at the present time, certain music services in which overseas troops are preferred, have not been available for hospital patients in this country. I refer to the latest phonographic recordings known as V-discs which are procured and distributed by the Division. Hit kits, moreover, are generally only issued to the permanent party, not to the patients in hospitals. If you desire these supplies to be issued to hospitals in this country, steps might be initiated to effect this objective.

Now let us turn a moment to hospital libraries. They are under the staff supervision of Special Services and provide an important source of diversion and therapy. A recent survey of hospital libraries indicates that the service in the general hospital has been generally satisfactory. But service has suffered recently from cutting the number of library assistants. Incidentally, the survey illustrated that hospital library service in station hospitals of less than 1000 beds is generally inadequate. Therefore, to the extent that reconditioning would be carried on at such hospitals, there would be even a greater need than now exists for improving library service at such places. Seeking to improve the hospital library service, the Office of the Surgeon General has requested that the special paper bound reprints, popularly called council books, containing thirty new titles each month, be made available to soldiers in domestic hospitals as well as to troops overseas. Special Services Division is anxious to make this possible. It is for the War Department to decide, however, whether it is feasible from a financial point of view to make these great little books available to the hospital libraries. If it can be done, it would indeed be a major advance in bettering hospital library service.

In the field of arts and crafts, Special Services procures for troops overseas a variety of handy-craft kits which includes leathercraft, metalcraft, model airplanes, show card kits, lettering and artists' sketch kits. Our division has trained personnel in the field of manual arts and at present the curriculum of the Special Service school now includes instruction in the use of handy-craft kits. But these kits are not now available for domestic distribution. If you believe, however, that our division can help in providing an active and masculine manual arts program then we would be happy to assist in obtaining supplies and trained personnel.

Finally, there is another segment of our activities which already plays a vital and immediate role in maintaining hospital morale. I mean the Army exchanges. The Special Services Division has almost completed a field survey of hospital exchange operation to see to what extent service can be improved. In view of dietary limitations and the fact that patients are confined to beds or are unable to purchase at stores in town, special procedures have been devised to make the exchange as efficient as possible in satisfying the needs of the patients. Results will soon be published so that commanding officers and exchange officers will be informed of those operating techniques found most popular in other hospitals.

These in brief are the activities in which the Special Services Division might be of use in your program. At the present time, a Special Services officer is authorized as a full time job for every hospital of two thousand population or over. Sometimes, however, the duty of an athletic and recreational officer has been assigned as an additional duty and the results have been correspondingly unsatisfactory. Moreover, the scope of a Special Services officer is generally restricted to duty personnel, with the Red Cross and occupational therapists handling the recreational program for the patients.

The Special Service Division, as you know, has a mammoth job in servicing healthy troops, so we do not search for new fields of endeavor. It is for you to decide whether we can be of any additional aid to you. If we can, please feel free to call on us. To repeat, if it is your wish, we will modify the training program of our school so that the various athletic and recreational specialists will come to your hospitals with a thorough understanding of the problems and objectives of the convalescent program.

COL. THORNDIKE: I think the Morale Services and Special Services have informed us of everything they will do to help us, and I assure you from my personal contact with General Osborne that he is vitally interested in all the aspects of the reconditioning program.

We will adjourn for lunch and meet at 1:15 here. I think there are some things that Lieutanant Kohn has in the way of materials and equipment which he will tell us about. General Dalton has not come in, so I presume official business has kept him elsewhere. The meeting is adjourned.

(LUNCH)

COL. A. THORNDIKE: Will the meeting please come to order? We have a busy afternoon and certain speakers, members in the conference, are planning to take the 5 o'clock train. Just a word of explanation. Anyone attending the conference who has not signed in or out with the Adjutant is requested to do so. There is a very important plan scheduled to be followed this afternoon. Just a word about the round-table discussion. On your blotter you will find the section to which you are assigned and you are to stay in that section one half hour and to proceed to the next. This evening's conference is directed to reconditioning in the service command and is naturally to include all members of the service command staff whether they are reconditioning directors, surgeons or otherwise. Anyone who is confused as to which group of the round-table he goes, can stop at the information desk which is directly outside the door. I left open this morning a little time for Lt. Kohn and so many people want to use this time I am going to ask him to come up and be as brief as he can.

LT. KOHN: I just want to call your attention to a mimeographed reference list for Special Service activities in hospitals which will indicate to you everything now available and can be had by either writing to us or to the normal distribution depot of the Adjutant General. That is all I wanted to say. If you do not have one of these lists, you can pick one up at the table to the rear to your left. Thanks very much.

COL. THORNDIKE: The next speaker is Colonel Reed, Seventh Service Command Public Relations Officer, who has some very important points that I think this conference should hear concerning the importance of Public Relations in hospitals.

LT. COL. R.W. REED: Thank you, Colonel Hillman. Gentlemen. I feel something like the guy that wore out the end of the bench for three years and then caught the eye of the coach.

I have been listening to the proceedings of this conference with a great deal of interest. I have listened to some of the discussion in the corridors and in the quarters, and it seems to me that you have here in the discussion of this program of reconditioning a very definite Public Relations problem.

Of course, Army Public Relations are involved at all Army hospitals to some extent but I think we are coming into a more acute period now, because the war has too many of our people, gone far away and is remote to them. They know it mostly and somewhat in a distorted fashion through the impressions they have gained from headlines, from the radio, and from the movies. They know little of the actual reality of it. So it is, therefore, that the hospitals present a specific Public Relations problem because they are the first to be caught, as it were, in the backlash of the war to an extent that causes their functions and activities to have a direct and definite impact upon the public. Consequently, the reconditioning program is one that requires the most careful consideration and planning from a Public Relations standpoint as well as from all others. It is here that the Army can achieve good Public Relations that will be helpful all along the line from training to combat.

It seems to me, in thinking it over, that the reconditioning program presents two distinct Public Relations phases. The first of these is the internal Public Relations of the hospital itself. Among the patients and their families and friends that come to visit them in the hospital; the impressions that they gain, not only by the visual observation of conditions and activities at the hospital, but also of the things that they are told by the patients themselves. You can imagine, I think, all of you, how a doting mother who comes to visit her son would feel about some things that she might learn at the hospital. When she learns, for instance, that her son might possibly be going back into combat, her immediate desire would be to take the boy home; she wants to do a little more mothering. She forgets that he has been a soldier and is expected to go on being one. People who come to the hospital must be made familiar with the problems of the reconditioning program and its objectives, so that their approval is won, so that they understand its importance and so that they will not incite the patient's mind with a constantly expressed wish that they should be home with their families and friends.

Second, the external phase is very important for several reasons. To begin with, there is the community in which the hospital is located. The local press and radio can help greatly in getting over the idea of the purposes and results of reconditioning to the patients themselves and to the people of the community in which they circulate while out on pass. More than that, however, correct handling of the presentation of news, pictures and featured articles from the hospital to newspapers throughout its immediate area can help in another important way. It can help condition the public mind generally to first, the fact that there is a military need for reconditioning and that as many men as possible must be restored to full duty. General Porter's remarks yesterday stressed this need as imperative, and that thought should point up much of the Public Relation activity in the hospital. Then there is the problem of the CDD. If he can be returned to his community sufficiently reconditioned physically to take on a job and do it well, he will be an asset, but the people in the community must also know that they have a responsibility to that man. His family and friends will greet him as a hero, they will pour sympathy on him and encourage him to take the attitude that "I have done enough", and soon you will have that type of patient back on the government such as we have had in the Veterans' Hospitals since the last war.

It seems to me that in projecting this program to the public, the reconditioning officers must, of course, keep in close touch with the Public Relations officers. There are a lot of human interest angles. I have seen a great many of them myself in brief visits around the wards.

There are some very inspiring stories here in a hospital like this, so not only should the Public Relations Officer be thoroughly familiar with the program, but he should have the sympathetic help of the reconditioning officer and also Morale Services Officer, the Chaplain and everybody else, to get this thing over. I am sure that at the Service Command, the Surgeon and Reconditioning Officer on his staff and the Service Command Public Relations Officer should work together to see that there is a smooth and efficient handling of this as a matter of considerable public interest. I leave these suggestions with you and I thank you very much for the time, Sir.

COL THORNDIKE: Thank you, Colonel Reed. Colonel Lynch has a few words he would like to say to us concerning some personnel problems.

COL LYNCH: Colonel Wright of the Sixth Service Command was discussing with me the other evening a problem which appears to be rather universal and I request Colonel Wright to state that question and then I will take it up.

COL WRIGHT: Colonel Lynch, the reconditioning program, as exemplified here and in many hospitals, is certainly a step forward. There are, however, many individuals who will be returned to duty not fully able to carry on active combat duty and yet, because of their usefulness and specifically because of the directions in Circular No. 293, they cannot be discharged from the Army by medical officers. Every consultant has seen a large number of these patients and every hospital has some who upon return to duty have been met by a rather unsympathetic and non-understanding attitude on the part of their line officers or equivalent commanding officers who have either assigned them to work for which they were not suited or told them there was no job for them in that particular unit and they didn't know what to do with them.

The result has been that many of these patients have been returned to the hospital. I personally have seen some who have been through this rather vicious cycle from six to eight times. It is bad for morale of the patient, the medical officers, and also for the other patients who have listened to the stories of these individuals.

The question, therefore, is this: May we have a discussion regarding what is being done or contemplated in the way of education or to influence the line officer to attack this problem of reassignment more intelligently and more seriously.

COL LYNCH: The problem as stated by Colonel Wright has been in the minds of the staff of the War Department for some time. We have no panacea for solving the problem as a whole. We have taken certain definite steps that we think will be of great help in solving the particular problem. As General Hillman stated yesterday, we have a tendency to swing from one side to the other on our various problems as though we were on a pendulum. Last summer and fall we were discharging men from the Army faster than we could get them in through Selective Service, which was a condition that could not be tolerated. Circular No. 293 was issued as a result of experiences obtained with Circular No. 161. It has been a matter of personal concern to me as Chief of the Enlisted Branch, G-1, as to whether or not we wouldn't swing too far the other way and end up with too many people that were non-usable. However, we are very wary of issuing too many changes in policy to the field because it not only creates confusion, but also starts minor swings in the pendulum. We have taken three definite steps in connection with correcting the situation referred to. The first step was a letter issued by the Chief of Staff to his major commanders on the utilization of personnel.

It was an extension of the policies published generally in Circular No. 293. The realization of the manpower situation has been rather forcibly brought to the minds of the major commanders in the last few months and we expect these effects to trickle down through the echelon of command. They should be down there by this time.

The second step in connection with Circular No. 293 was to make an amendment which I have referred to already. It appears in Circular No. 100--a policy stating the command's duty, with respect to enlisted men's physical condition. Unfortunately this was buried in a paragraph which referred to physical standards for men going overseas and its position escaped our notice in getting out the original 293. The revision which I will read, has now been placed in the policy part of the circular, and includes provisions for implementation. The policy now reads: "Each commander must evaluate the physical condition of his men and apply prompt corrective measures through training or medical treatment. When a defect is discovered which disqualifies a man for oversea service, or which requires special consideration in assignment, the examining authority will notify the man's unit commander of the defect and appropriate notation will be made on Soldier's Qualification Card under "Remarks" and on Service Record under "Remarks, Administrative." When a disqualifying defect has been corrected or materially improved, the proper agency will notify the man's unit commander and appropriate action will be taken to modify the previous notations."

To implement that, a form letter has been prepared and instructions for that follow in the next section: "When a defect which requires special consideration in the assignment of the individual concerned or which disqualifies him for overseas service is discovered at a hospital or other medical installation, the medical officer concerned will transmit to the man's unit commander data necessary to permit proper reclassification and reassignment in keeping with the man's mental and physical capabilities.

"Similar notification will be furnished when the medical officer determines that a previous defect has been corrected or materially improved.

"Upon receipt of the information mentioned above, the unit commander will take the action required by paragraph 2i (which I have just read to you).

"It is the commander's responsibility to give the individual an assignment appropriate to his mental or physical capacity as outlined in the notification."

The text of the letter is not particularly important. The third action that has been taken was, effective the 15th of February, to establish three War Department reassignment centers. These reassignment centers are to take care of certain categories of personnel, only two of which are of particular interest to this conference. Battle casualties other than Army Air Forces discharged from the hospital who are capable of performing useful service other than in the arm or service to which currently assigned, are assigned to a War Department reassignment center from the General Hospital in order to be properly reassigned to include retraining if necessary, before they are disposed of. These reassignment centers operate at War Department level similar to Reception Centers. Another category of personnel includes those whose physical and mental capacities might be utilized if reassigned. It does not include those clearly below the minimum standards.

In review: The policy is that each of the three major commands must exert every effort within their jobs and assignment capabilities to reassign the man in accordance with his physical condition and his other training and capacities. If they find a man is non-usable, they report him to the War Department. The Adjutant General issues orders transferring him to a reassignment center. There he is reevaluated by an experienced and selected personnel, both medical and classification and the man is reassigned. He may be sent back to his own branch. The question of keeping these from bouncing has not yet been solved under the new set-up. We have not yet had sufficient experience but it will probably end up by the commander being told he has the man and it is his problem to use him in accordance with the new version of Circular No. 293.

There is another aspect which has not been solved as far as a publication is concerned. We have a category of personnel discharged from General Hospitals and other medical installations which, with this letter, are qualified to go back to their unit but not for full duty. A plan has been discussed heretofore but concurrence has not been obtained from the Army Ground Forces. The plan is to return such personnel to a replacement training center of their arm or service, at which place they may be used as trainors or given refresher training which will permit them to develop technically as well as physically in that carry-over period until they are ready to assume full duty. That plan has not yet crystallized into any publication. That about covers the point on the question that Colonel Wright raised. I know it is not a complete answer, but we hope that general indoctrination plus what we have done will solve it. While I have the floor, I'd like to thank Colonel Winn and representatives of the Seventh Service Command for the excellent accommodations and facilities which have been provided for this conference. I would also like to review from a layman's and from G-1's point of view, certain aspects of the reconditioning problem. General Hillman touched on it in general terms last evening. Our principle objective is to restore the patient to his place in the ranks with the least possible loss in time. We must keep our eyes on the ball and not let the reconditioning program become so elaborate that it detracts from the essential point of our mission.

The second feature is that in my opinion, it should be constantly emphasized to the patient -- which is a term I do not particularly like -- that he is still in the Army. I noticed that at the roundtable discussion yesterday they used the term "fellow patients." That should be discarded. They should either be referred to as "men" or"fellow soldiers." I think a great deal of the problem can be solved if you develop the "can do" attitude. That is merely a term that is used by some professional military men to describe a state of mind. You have referred to it when you stated that your leaders in this reconditioning program must be sold on their part of the work. The "can do" attitude means that you not only can do, you will do it, and you are going to do it. I happened to be reading a piece in the paper this morning which, I think, exemplifies the point of view. It refers to a story of building bridges across the Dniester River. The men usually cut their own timber and rely on pioneers to build the bridges. These pioneers aren't specialists. I once asked a Pioneer officer where he learned to build bridges.

"Nowhere", he said. "Anybody can build a bridge." I said I thought it depended on what sort of bridge you wanted. He said no, if you had to have a bridge you had to have it, and that he could build a bridge across the English Channel if he had to.

"That's the way they look at it. If there's a river to cross the Red troops have got to cross it, and the Pioneers do the bridge-building job with what is available."

That's what I mean by the "can do" attitude. Instead of sitting around and complaining that you don't have the facilities and equipment to do a job, you find out what the job is, what you have to do, then you say "can do" and do it.

COL THORNDIKE: Thank you, Colonel Lynch. Colonel Winn, do you want to explain to the conference how you handle the placement of cases that might be troublesome?

COL WINN: I don't know that I can add very much to the subject. When we first began operating under Circular 293 we had considerable doubt in our minds as to how we could implement that document. We had been discharging men by CDD in accordance with the directives existing at that time. When this circular came out, of course, there were large numbers of those men who were fitted for some kind of duty and we made an attempt to salvage them. In order, in our minds, to help the reassignment centers, we had these men interviewed by a Classification Officer of the Adjutant General's Department whom I had made special efforts to obtain from the Seventh Service Command. He is a psychologist, one who has had training in vocational direction and in War Department classification. In addition to the other duties of this officer, he interviews soldiers at the request of their own officer before the soldier's appearance before a Disposition Board, or if he hasn't seen fit to request this assistance - it frequently happens that a disposition board feels the need for some sort of advice and sends the soldier to this officer. The Classification Officer makes a written statement which becomes a part of the soldier's clinical record and which is available at the time he appears before the Disposition Board. It is shown so that the Disposition Board states definitely what types of duties the soldier cannot perform. We haven't felt that it was feasible to enumerate the jobs a man can do. We have preferred to state his limitations. I notice that the new circular provides that that be done rather than state duties that he can do. To go a bit further, we attached a copy of this Classification Officer's recommendation to the Form 20. We have been doing this for several months and now it has been made a part of the Form 20 and a part of the service record. However, we have simply been acting on our own initiative and have stapled to the Form 20 this Classification Officer's opinion, hoping it would help in the reassignment of these men. I can't say exactly how successful it has been. We have not been too encouraged because of letters we have received from these soldiers who have gone. Some of them have voluntarily written back. One man who certainly shouldn't be in an overseas combat unit and shouldn't be in a cold, damp climate, and who was recommended for duty in a warm, dry climate, sent me his reassignment orders and had written across the top, "And this is what you call a warm, dry climate". He was assigned to Camp McCoy, Wisconsin in a combat division. There have been other instances of men with rheumatic fever where we have made the same sort of recommendations. They have been returned to the same source from which they came to us. They then have again contracted rheumatic fever and they have returned to the hospital suffering with it a second time.

COL LYNCH: I might explain, Colonel Winn, how some of those things come about. We ran into that only recently. When those men were reported to The Adjutant General, most of them were assigned to the Army Ground Forces based on information furnished to The Adjutant General and the assignment people didn't have all of that information. They sent him to a division, and after he got to the division the correspondence with the Ground Forces began and some of it is still going on.

That accounted for the men with rheumatic fever because we have been checking up on those particular angles. They were just reported in as infantrymen, qualified to go back to duty without any qualifying remarks at all. Now, I think that with the instructions for assignment of patients to reassignment centers or to R.T.C.'s, we can overcome most of that.

COLONEL WINN: We have made an effort for quite a long time now to give as much information as we could to the post to which the man is returning. We have sent them copies of the Disposition Board to which was attached a transcript of the soldier's clinical record. We found to our dismay that at one center to which we were sending men that about 50% of them were given C.D.D.'s. Our Disposition Board record was being thrown into the waste basket and the surgeon never saw it, so we started sending it to the surgeon. I would like to give this rough estimate. I am not quite sure of these figures. We have had a little private arrangement between our Classification Officer and the individual because we are interested in this proposition. He has asked them to write to him a personal letter, telling him whether or not he was satisfied or whether he thought he had been properly assigned. Of the replies which have been received - I think Major Johnson can correct me if I am wrong - about 20% have apparently been assigned satisfactorily. 60% were fairly satisfied.

MAJOR JOHNSON: We received about 20% informal replies from those who left here, and 60% of those soldiers said they were satisfied; 20% considered it fair enough, and 20% felt they had been poorly assigned.

COLONEL THORNDIKE: I think this problem has been pretty well aired. I think we all understand the difficulties under which we work and will look for a solution as promptly as possible, but it is only by cooperation and not by informally discussing this problem that we get results. I am sure that Colonel Lynch understands the problems that the Medical Department is having. We now go on with the program. The next speaker is Major Bues, Military Personnel Division, ASF Headquarters, who will speak on the subject, "Personnel Requirements in the Reconditioning Program". Major Bues.

MAJOR BUES: In personnel requirements for the reconditioning program, it seems to me there are four things which have to be considered in arriving at a yardstick. First, I think we will have to admit that they are unknown quantities but when combined will furnish us with information upon which to base an over-all personnel requirement.

First, it is the motivation of the trainees.
Second, the activities which must be supervised.
Third, limitation on size of groups, and
Fourth, individual contact required for both physical and mental development.

The motivation of the trainee in many instances can cut down an untold number of men required for the total reconditioning program throughout the country. Insofar as the reconditioning officer is successful, along with the help that he has in motivation, by that much will the need for additional personnel be reduced. There are certain activities which, regardless of motivation, must be supervised. I recall quite well, back in the days of the Civilian Conservation Corps, that during the spring season in some camps more men reported for sick call because of injuries on the athletic field than because of injuries on the work projects; also at least an equivalent number of hand injuries took place in the woodworking shop as took place on the work projects.

The answer was fairly obvious. The work project was much more adequately supervised than were either of the two other activities.

There are but two reasons why the requirements are unknown. The constant pressure which all of us have felt for reduction of personnel on overhead activities, with the constant pressure for increase in efficiency have confused many of us in the personnel business because the tugs and pulls and the pushes come from so many different sources at so many different times. Frankly, I have no idea how many people will be required and I doubt that the number required will be a very straight-line function of the number of trainees in the program. I believe that the number required per trainee of personnel will be reduced as experience is gained. I am sure you know in Service Command installations, that there is a bulk allotment of personnel, both commissioned and enlisted, made from the War Department to the Service Command as a whole. Where that personnel is used is not a function of Headquarters, ASF. It is a function of the Commanding General of the Service Command. In T/O organizations, it is determined through experience that a certain number of men with certain types of skills are required for the formation of a unit. Therefore, there is a definite number of men for a kind of unit which will have a specific mission to perform. As is the case in Service Command installations, so it is with T/O units, however bulk allotments permit greater freedom and therefore seem more logical for service command use. They do perform many missions which were not contemplated for them. I will say that the Military Personnel Division of the ASF will do all in its power to make the necessary over-all adjustments that might be required by Service Commands. At the same time, however, because of the decrease of activities in the Service Commands, the overhead personnel will be reduced each quarter of the year.

From a classification and assignment standpoint of the reconditioned men, there is quite an interesting, history which perhaps you know and perhaps you don't. In the beginning days when the Selective Service law first started to operate, those of us who were engaged in the vocational classification and assignment of personnel had very close contact with the Office of the Surgeon General, mainly for educational purposes on the part of all concerned. However, from a functional point of view, as soon as the physical standards had been set and Induction Station Commander said a man was in, the classification officer became the key man and said, if a man was a lawn mower in civilian life, he should be a lawn mower in the Army, thus we capitalized on, and I believe properly so, civilian skills. We were a long way from combat as we now think of it. We had to find men to interview; we had to find men to type the records, etc., until we had our service built up to where we could be of real service to the men who were going to be trained as combat and combat support troop.

Now we have come to the tag end of that operation and we find ourselves being much more closely allied with the Office of the Surgeon General because of the terrific physical implications that must be taken into account when a man is reassigned within the Army after he has been hospitalized. We are not in a position to worry too much about capitalizing on his civilian skill as we were in the beginning days. As a matter of interest, I believe General Hillman will back me up in this, our Division has had more conferences with the Surgeon General's Office since about the 9th of February than it has had in any equivalent period since the war started, due to the fact that we are at the conservation angle from a physical point of view rather than a capitalization on the civilian ability that might be represented by military personnel.

Where in the process of reconditioning should there be a classification officer?

It is questionable in my mind that every general hospital would have use for a classification officer, at least on a fulltime basis. I believe, however, the traveling teams that have been set up in the service commands with their key officers can be of great assistance in training certain personnel within the hospital to assist in interpreting what the medical profession has to say about the limitations of this man physically and in attempting to interpret those into "What can this man do vocationally when he is reassigned?" There have been some developments of a positive nature along the CDD line. They are still in the experimental stage, but I believe are available for such hospitals as would care to request them. They are rather extensive and are essentially AR 615-26 in reverse. The military occupations have been broken down on one side of the page and a corresponding civilian field or fields listed on the opposite side of the page. In other words, in the beginning, we capitalized on civilian skills and tried to interpret them into the military skills. Now we have men who have military occupations with skills which are utilizable, by interpretation, back in civilian life. I think those might be helpful in the CDD cases.

In the Reconditioning Program in terms of both the personnel requirements and the assignment of personnel after they are released from reconditioning, there must be an ideal program. However, as we now are operating, it is my opinion that the control will be and must be the number and kind of personnel that we have that can be allotted as additional help in the program as well as the exploitation of the trainees and the capitalization on what they represent as trainor personnel.

In conclusion, I would mention that in the beginning days of activations it was a rather common saying that a division commander who did not train his cadre four deep would have no cadre at the end of six months because new divisions were used as a parent organization for the formation of other new divisions. By that very method of training, three or four deep, he not only speeded up the training of these men, he not only trained more of them, but he ended up with a better organization. Insofar as that can be applied in whole or in part to the trainees in the reconditioning program, it should be. By that I mean the more of them you are training as instructors, the more rapidly will all of them be available for reassignment. Thank you.

COL. WINN: Colonel Thorndike, I would like to say this in explanation of this Classification Officer we have acquired. We haven't felt that anybody on this post should have a full time job. This officer is used as Administrative Ward Officer for three NP Wards. He relieves the medical officer of all routine duties such as property responsibilities, passes, etc. He is a psychologist and is competent to make psychometric tests which are necessary in NP cases. If he doesn't make them, the doctor has to make them, so we are saving the doctor's time again. He assists our own Personnel Division in reclassifying our duty personnel, and, in addition, does the work as I described for questionable patients.

COL. THORNDIKE: Next on the program is Miss Eleanor C. Vincent of the National Headquarters of American Red Cross. Most of us in Washington have come in contact with Miss Vincent. She is very busy doing a lot of good work and we know that the Red Cross in the hospitals is a most important activity. Miss Vincent.

MISS ELEANOR C. VINCENT

General Hillman, Colonel Thorndike, and Colonel Winn. Red Cross workers in hospitals and volunteers greatly appreciate the privilege that Mrs. Swiggert and I have to attend this conference, and we hope as a result of the discussion which we have heard that we, as Red Cross Workers in the hospitals, will further the Reconditioning Program.

Red Cross medical social work was established in Army and Navy hospitals to meet a need similar to that which had been recognized in civilian medical practice. A need existed for social data regarding patients, which enables the physician to know the patient as well as his disease and for assistance in solving those social problems which are retarding the patient's response to medical care.

The first psychiatric social worker was requested by The Army Hospital for Functional Neuroses, Plattsburg, New York, in 1917. Immediately thereafter, a request for a medical social worker was received from the Commanding Officer at Chelsea Naval Hospital. Because of the chartered obligation of the Red Cross to serve the sick and wounded of armies, the National Organization immediately complied with the requests of the War and Navy Departments. A professional social work staff was then assigned to which were added recreation personnel, to plan and supervise medically approved recreation for convalescents and to coordinate the activities of individuals and groups who desired to serve hospitalized men.

The Red Cross social service unit is a department of the hospital, responsible to the commanding officer for the conduct of the Red Cross Program as agreed upon between the Office of The Surgeon General and the American National Red Cross, and as outlined in Army Regulations 850-75. The worker who heads the staff also is administratively responsible to the hospital unit of Military and Naval Welfare Service in the Red Cross area office for the operation of the program and the quality of performance. She in turn receives professional guidance and supervision from the area hospital executive and advice from the consultants in the psychiatric casework, recreation and educational fields.

The function of the Red Cross in military hospitals is social casework for patients and duty personnel, medically approved recreation for convalescent patients, and the recruitment, training and direction of volunteers.

Since reconditioning emphasizes recognition of the patient as an individual, the significance of the doctor-patient relationship and the importance of the patient's understanding about his condition, it parallels completely the basic concept of medical social work--that the social worker should help the sick or injured person to adjust to the limitations which his condition involves and encourage him to carry out the treatment recommended.

The social worker also supplements the medical officer's understanding of the patient through knowledge obtained from the patient or his family through the home chapter. Her assistance may be sought by the medical officer to further the patient's understanding through repetition or restatement of his recommendations, and when indicated, she interprets to the medical officer the subject upon which the patient needs more assurance from him. This supplemental assistance from the social worker is just as important to the man returning to active duty as to the man who is determined unfit for further military duty and who, handicapped, must resume community life.

Another function of the social worker is to adjust those personal and family worries which disturb many patients and thereby affect their response to medical treatment. The fact that duty hours are prescribed for all patients throughout the day imposes upon the medical, nursing and reconditioning staffs the need for a keen awareness of tension due possibly to worries <u>real</u> or without foundation; to make <u>sure</u> that continuous physical and mental activity does <u>not</u> leave the patient without <u>opportunity</u> to present these worries to the member of the hospital staff whose concern they are.

It is important for us to remember that whereas physical and mental activity may relieve tension, it does not solve personal and family problems;

therefore medical, nursing and reconditioning officers should be alert to possible social ills and ask the Red Cross worker to see the patient to offset the possibility that the patient may not have time to seek out the social worker.

The family worries of the patient to be returned to duty, the patient to be discharged for disability, and the patient to be discharged upon expiration of term of duty are all similar, whereas the personal needs of the man to be discharged for disability demand the social worker's specialized effort in that he requires assistance in recognizing and accepting his disability; explanation of and assistance in applying for government benefits. Further, it may be supremely important for the social worker to interpret to his family the patient's attitude toward his condition, and all the implications of his physical limitations.

Recreation is part of all normal living; therefore, the War and Navy Departments, when requesting social service of the Red Cross, asked that our organization assume responsibility for planning and conducting medically approved recreation for patients. In military hospitals this has been of importance since patients remain until returned to duty or until they have reached the maximum benefit of hospitalization.

The Red Cross also was asked to coordinate the activities of individuals and groups who wish to serve hospitalized men. It has been the function of the Red Cross recreation worker to discover the recreational needs and interests of patients, and on this basis to plan and conduct a recreation program which sustains morale and provides emotional release. This program is adjusted to the disabilities of the patient and the necessary restrictions of the hospital setting. The Red Cross recreation worker stimulates patient participation and utilizes in the recreation program the leadership abilities of patients, hospital personnel and volunteers from the community.

As the Red Cross Department of the hospital reports to the Commanding Officer, recreation, as social service to individual patients, is under the direction of the Ward Medical Officer. In addition to reports to the Commanding Officer regarding the total Red Cross program, approval is requested of the Executive Officer, of each week's schedule of recreation activities. The Red Cross hospital executive and the head recreation worker consult frequently with the Chiefs of Services regarding ways and means of improving the quality of group recreation as regards both patient and community participation.

Recreation as conducted in military hospitals varies from that in state and private hospitals. In civilian institutions, recreation, with few exceptions, has been conducted by the occupational therapy department. In Army and Navy Hospitals since 1917 and 1918, recreation has been included in the social service program of the Red Cross. It is interesting to remember that at one time the American Red Cross, through funds and professional personnel, sponsored occupational therapy in hospitals of the Navy, the U. S. Public Health Service and the Veterans' Bureau, and at the same time conducted social case work and recreation.

Whereas Circular Letter No. 149 states that "Red Cross recreation may include arts and crafts and hobby activities when used for diversion and leisure-time recreation," the recent War Department letter from The Surgeon General, dated 26 January 1944, provides that all handicraft shall be under the direction of the Occupational Therapy Department. Therefore, effective immediately, wherever an Occupational Therapy Department has been established, irrespective of the number of staff, the Red Cross will discontinue all diversional handicraft, including crafts and hobby shops in rooms assigned to the Red Cross for recreation activities.

The Red Cross will continue handicraft as one of its diversional activities only in those Army Hospitals where there is no occupational therapist.

AR 850-75, paragraph g, lists as one of the services to be performed by the Red Cross in Army hospitals: "To represent the Commanding Officer in coordinating the efforts of individuals and groups in the community who desire to serve the hospital". Therefore, through volunteer special services of Red Cross Chapters adjacent to military hospitals, qualified women have been recruited and trained in the hospital desiring their services in order to render such supplemental assistance as may be required by the Red Cross professional staff. These volunteers represent the membership of Hospital and Recreation Corps or the Gray Lady Unit thereof, and the Arts and Skills Corps. Until the present time, both of these groups have aided the Red Cross recreation staff in all of its activities. The Motor Corps as well as Canteen Corps render supplemental assistance as required.

Upon the request of The Surgeon General for the continued interest of Red Cross volunteers in the handicraft program of the Occupational Therapy Department, the National Director of Volunteer Services has agreed that members of the Arts and Skills Corps recruited and reporting to the Red Cross hospital executive, when so requested may be assigned to work under the supervision of the Chief Occupational Therapist. Also, members of the Gray Lady Unit who have been trained to perform varied duties for the social workers and recreation workers may give part of their duty time in the handicraft program under the Occupational Therapy Department. In the event there are an insufficient number of volunteers to render the service requested by the Commanding Officer and occupational therapist, the number of persons and the particular skills desired will be reported to the Red Cross hospital executive, who will secure the cooperation of the local chapter in strengthening the membership of the corps.

The hospital Red Cross executive, upon request will make available to the Reconditioning Officer the services of selected members of the Gray Lady Corps to aid in the educational program, and when specialized instructors are desired, will seek to obtain them through the cooperation of the local Red Cross chapter. These volunteers may be men or women, and it has been agreed that any orientation to the Army setting will be provided by the Chief of the service to whom the volunteer is to report for duty. The Army will be responsible for their military clearance.

The American Red Cross, in its recreation activities, has agreements with several national organizations interested in serving hospitalized men; these include, the National Garden Clubs of American, and the National Federation of Music Clubs. The latter project will receive added impetus as soon as a pamphlet describing music as a phase of the Red Cross recreation program in Army and Navy Hospitals is released to its membership. The possibility of using selected volunteers from the Garden Club in a reconditioning program is a matter to which we are calling the attention of our hospital executives for consideration with the Commanding Officer and reconditioning staff.

Whereas, it is understood that there are federal monies allocated for the purchase of all necessary equipment and supplies for the reconditioning program, any items not available through this resource may be discussed with the Red Cross hospital executive who, through any existing Camp and Hospital Council Service, may find it possible to obtain the articles desired. As you know, in an effort to correlate the interest of communities desiring to make material gifts to camps and hospitals, Red Cross chapters assumed leadership in organizing Camp and Hospital Councils through which

the Commanding Officer and Red Cross as executive could make known those supplemental items which would add to the comfort of duty personnel and hospitalized men. Such articles not available through military channels may be requested by the Commanding Officer with the understanding that no public appeal for funds for the purchase of such items will be made, but rather the opportunity proffered to the Council membership to meet the request.

We have urged the Chief of Hospital Service in each area office of the Red Cross to make herself known to the Chief Surgeon of the Service Command. She will now be advised that in her visits she should ask the Surgeon to arrange a joint conference with you so that problems as well as achievements may be shared. This should be one additional means of enabling us all to achieve our common goal, namely, the best possible service to the disabled men of our Armed Forces. Thank you.

COL THORNDIKE: Thank you very much, Miss Vincent. The meeting is now open for discussion. Are there any questions? No more discussion? General Hillman has a few remarks.

GENERAL HILLMAN: I believe that this is the last session at which all of the members of the conference and their guests will be present. I would feel very much amiss if I did not take this occasion to express the great satisfaction I feel as a result of this conference. It has given me an opportunity to become very much better acquainted with our problems and to become acquainted with you who have directed the reconditioning programs in your respective service command hospitals. I shall go away from here with the feeling that this two-day conference has been very much worth while.

The success of the conference is attributable to the interest and alertness all of you brought here--the delegates, the representatives of the various divisions in Washington, as well as to the fine demonstrations which have been staged here by Colonel Winn and his staff, and to the efforts of everyone who has been in attendance.

I wish particularly to express my appreciation for the work of the press in covering this conference and their very apparent desire to attain a full understanding of what our objectives are and of what our approach to our many problems is. I wish to express my keen appreciation of the arrangements which have been made through the Commanding General of the Seventh Service Command for carrying on this conference. I wish to express personally to Colonel Connor the thanks of the Surgeon General for the untiring effort he has shown in setting up the details and making a transcript of this conference so we may all take home a complete record of all that has been said and, in this way, have it for reference in the future. Lastly, I wish to thank Colonel Winn personally and the staff of the Schick General Hospital for the very fine care that we have received here. I want to thank him for the arrangements for the conference in this building, the demonstrations which have been given us, the fine quarters he has provided and the fine mess he has served, as well as for the smoothly working administrative machinery which has caused all these things to be supplied us without concern on our part. I wish to thank each and every one of you for your contribution.

COL THORNDIKE: The meeting will adjourn until three o'clock when the round table conference will be held. This evening's conference at seven thirty will be held in the Medical Library.

END OF CONFERENCE